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Here's Michigan's Medical News Magazine . . .

Please flip page by page and read timely articles about arbitration, practice management, Medical Practice Board, HSAs, Judicial Commission, other topics of concern to every MSMS member. Michigan Medicine *takes on a new purpose and a new look this month.*

– Ernest P. Griffin, MD, Chairman, MSMS Council.

MICHIGAN MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 1 JANUARY 1976

Michigan Medical Practice Board is threat only to doctor who violates Medical Practice Act, stresses Board Chairman Van Duyne on page 12.

Success for Malpractice Arbitration Program relies upon practicing physicians, writes MSMS President Brush on page 4.

"Dear Governor, MSMS will provide series of position statements re recommendations of PHSRP." Read pages 34-35 for some basic understanding of complex state laws.

Annual report describes positions taken by MSMS Judicial Commission. Doctor Grigg discusses eight major issues handled in 1975. See pages 38-41.

Practice management feature tells how to figure out new Michigan single business tax. Put pages 50-51 in your files.

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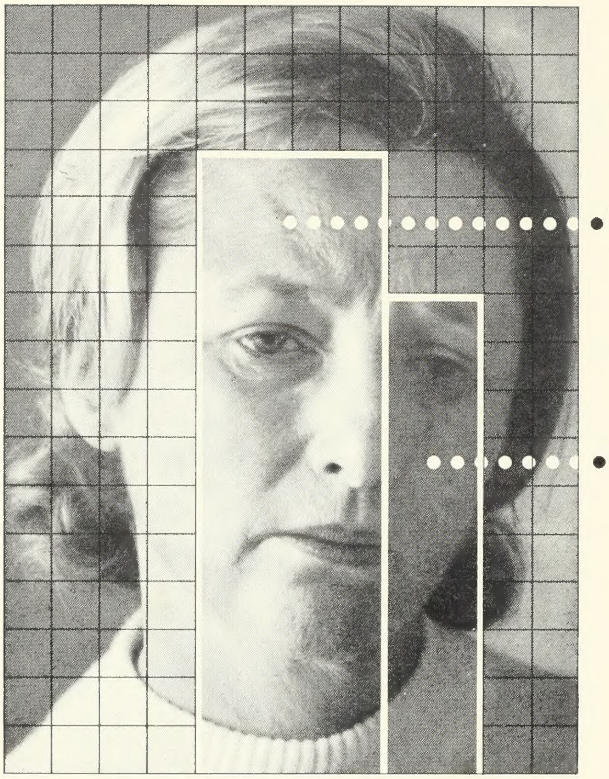


Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

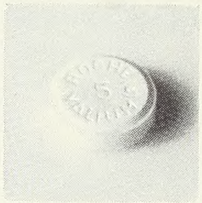
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

Beginning Now . . .

Your MSMS journal has a new challenge. The MSMS Council adopted a recommendation of the Publication Committee, "that **Michigan Medicine** *be dedicated to provide useful information for Michigan physicians about contemporary issues and actions of MSMS with special emphasis on socio-economics, legislation, and news of medicine in Michigan."*

In beginning this new format, with this month's issue, we thank John W. Moses, MD, Detroit, for his seven years of distinguished service as our scientific editor. Doctor Moses continues as an extremely busy man – the new president of the Wayne County Medical Society, member of Michigan Medical Practice Board, member of AMA Council on Medical Education, and director of medical education at Mt. Carmel Mercy Hospital, Detroit.

We encourage every MSMS member to read this issue carefully and to watch for the February issue.

James H. Tisdel, MD
Publication Committee Chairman

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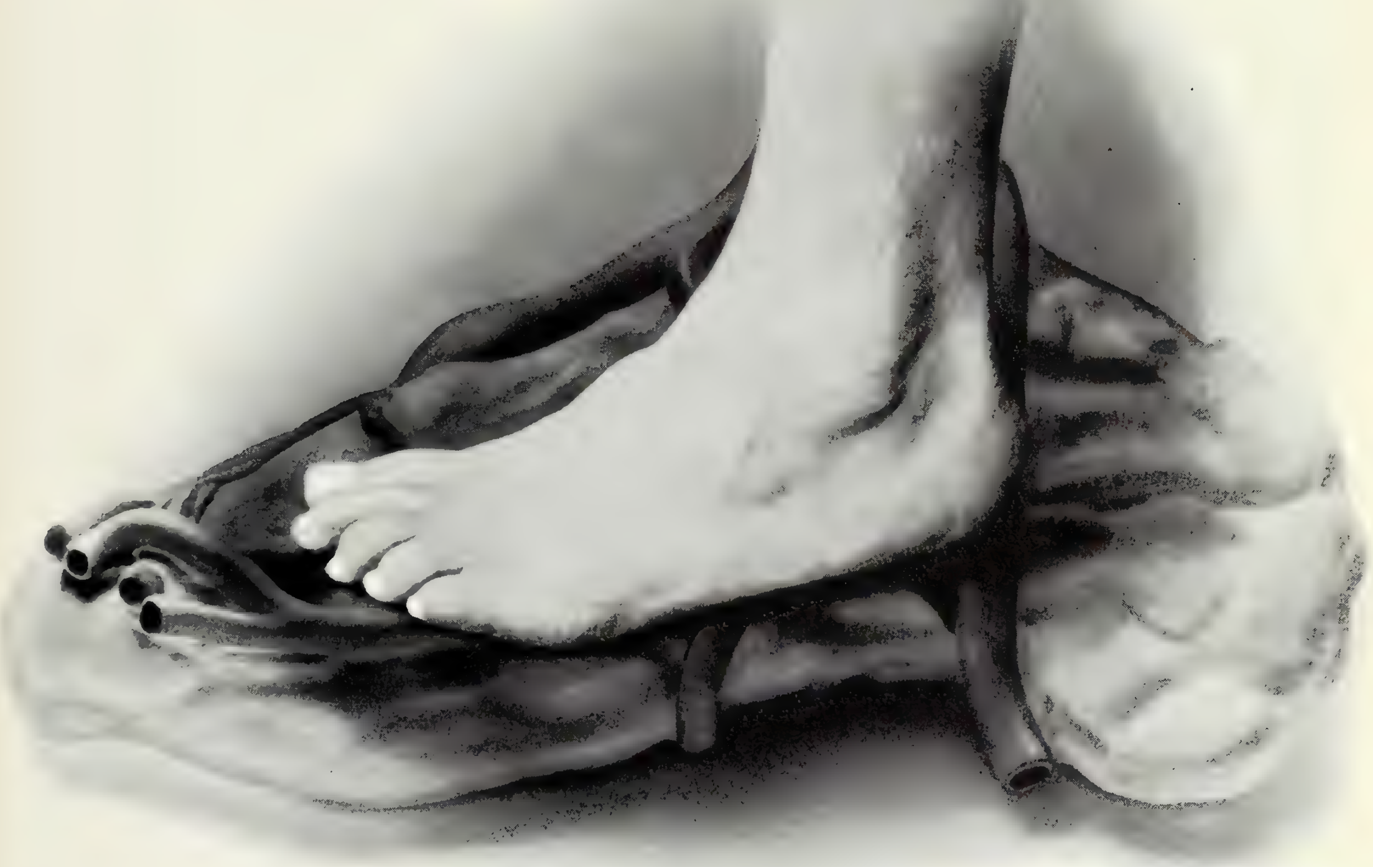

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Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

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Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

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PRESIDENT'S PAGE

Brock E. Brush, MD
MSMS President

Physicians Responsible For Success of Arbitration

On January 1 of this year Michigan embarked on a new experiment in settling medical malpractice disputes. Voluntary, binding arbitration is now an established legal option for patients, doctors and hospitals.

The Michigan State Medical Society supported arbitration as one of the cornerstones in a new structure to resolve the professional liability crisis which crashed down upon us in 1973. Now we are deeply involved in its implementation. Arbitration is a challenge that medicine should face with enthusiasm and vigor.

A year ago today we were at sea in the professional liability crisis. Malpractice allegations were rising, insurance premium rates were escalating, courtroom judgments were skyrocketing.

Physicians were crying out for alternative litigation in the courtroom, which was costly, time consuming, and questionable in its fairness. Voluntary, binding arbitration is that alternative.

With a new public policy limiting contingency fee charges by attorneys, with insurance availability assured by either the state or the medical society, and with arbitration, the three most perplexing problems we faced a year ago have been met directly.

Now arbitration is on the anvil of actual use. There are many questions to be answered. In fact, the Legislature wisely included a section in the new arbitration act specifically calling for a review of arbitration after it has had three years to function.

The vital questions are: Will patients accept arbitration in lieu of their constitutional right to go to court? Will doctors, hospitals and clinics take the time and effort to encourage patients to take advantage of arbitration? Will the act stand the test of constitutionality which is certain to come?

I have been told by attorney friends that, indeed, arbitration is a time-tested and constitutional means of resolving disputes, and the act should be upheld by the courts.

I am encouraged by the interest and dedication of the State Bar, Physicians Crisis Committee, and the Michigan Hospital Association, as well as organized labor and other groups, in their efforts to implement arbitration and make it work for medical malpractice cases.

I suspect that most patients, given understanding and guidance by their doctors, will choose arbitration instead of going to court. In California less than 5% of patients have rejected arbitration.

But that understanding must come from their physician. The success of the arbitration program relies heavily, if not exclusively, upon the practicing physician.

MSMS advocates arbitration.

A great and new and exciting challenge lies before us all in our continuing efforts. It is to do our part fully, professionally and vigorously to make arbitration work.

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How do you benefit as an MSMS member?

– By being eligible to participate in the MSMS group life insurance plans, available in term and permanent (ordinary, whole) forms.

All active and associate members of MSMS under 70 years of age who are active in medical practice or in a professional position are eligible for participation.

1. They may enroll for $10,000 of term insurance without evidence of insurability within 60 days of joining MSMS. Beginning this month, the amount of term insurance offered to MSMS members has been quadrupled to a total of $100,000. (Complete information on the expanded term insurance is being mailed this month to all MSMS members.)

2. Members may convert $10,000 term insurance after one year to the permanent (ordinary, whole) plan, with the security of level premiums and cash values. By electing permanent insurance in lieu of term insurance, a member can provide for the continuance of $10,000 of insurance with no reductions so long as premiums are paid and membership in the society is maintained.

If a member is totally disabled, his premiums for both term and permanent plans are waived during the entire continuance of disability, or until age 70 in the case of the term plan.

Participating members are eligible to share in any dividends that become payable under both group term and group permanent plans because of favorable claims experience. Dividends are based on the experience of the group each year, and in 1975, dividends represented 3% of premiums paid.

Conversion privileges are a part of both plans.

The MSMS plans are underwritten by the Mutual Benefit Life Insurance Company, Newark, NJ.

Further information on premiums, payment of benefits and other details may be obtained from Stratton-Cheeseman and Associates, Inc., PO Box 1563, East Lansing, Mich. 48823.

(Next month in membership benefits: MSMS workmen's compensation insurance for physicians.)

How It Looked — The 1975 MSMS Scientific Meeting

Brock E. Brush, MD, MSMS president, received his share of the limelight, as in this situation when Detroit TV personality, Doris Briscoe interviewed him on the "death with dignity" issue.

REGISTRATION

Registrations for the 1975 MSMS Scientific Meeting totalled approximately 1,600, with 1,200 of them Michigan physicians. MSMS staff, including Margaret Berry, above, were kept busy during the three-day event at Southfield.

Attentive crowds, armed with pencils and tape recorders, paid close attention to the more than 130 speakers, panel leaders and discussion leaders who presented the latest information on key scientific, political, socio-economic subjects.

They kept their audience at attention with their fine sense of humor, rapid delivery and store of hilarious comments on lobbying, and then Gene Dyson, left, and State Sen. Earl Nelson broke each other up after the MDPAC session during the MSMS Scientific Meeting. Mr. Dyson is president, Georgia Business and Industry Association, and a nationally-known speaker on legislative action.

Among the out-of-state speakers attracted to the Scientific Meeting was P. C. Thompson, MD, of the University of Tennessee, Chattanooga. His topic, which drew considerable attention from physicians and news media, was "Total Ankle Replacement."

Among the notables at the Scientific Meeting was Detroit Lions' team physician, Edgar J. Geist, Jr., MD, Rochester.

MICHIGAN STATE

Animated discussions of a vital subject, professional liability insurance, were frequent throughout the three-day meeting. This group includes Vernon V. Bass, MD, president, Michigan Physicians Mutual Liability Company (back to camera, left).

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A favorite exhibit with physicians attending the meeting was the one presenting lifelike models of human body parts. Examining the skull constructed for teaching purposes are John B. Tauscher, MD, left, and Paul Morin, MD, both of Flint.

Gerald A. O'Connor, MD, Ann Arbor, U-M team physician, led a well attended session Tuesday afternoon on the diagnosis and treatment of common athletic injuries.

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Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

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The "New" Medical Practice Board – Its Members, Leaders and How it Will Perform

Frederick Van Duyne, MD, Flint, sees himself as newly-elected president, and the other members of the Michigan Medical Practice Board, as trapped in a triangle of pressures.

"The press and public are saying we must act now. But the legislature says we can't have any money. And then there are the MDs who wonder if we're setting up a Gestapo in Lansing," he says.

Each of those pressures is cause or result of the mountainous responsibilities now in the board's hands following a series of new acts passed since 1973.

The board licenses and relicenses all Michigan MDs and administers the semiannual FLEX (Federal Licensing Exam) to approximately 1,500 aspiring Michigan MDs.

With the passage of the Michigan Medical Practice Act in 1973, the board was given the power to suspend licenses of Michigan MDs who are incompetent, drug and alcohol addicted, and break the laws. This is carried out through a process of hearings nearly as complicated as criminal court proceedings.

Doctor Van Duyne

With the new malpractice laws of 1975, the board has gained responsibility for fingerprinting all newly-licensed Michigan MDs, for certifying all Michigan MDs for the 50 hours of continuing education now required annually of each and for keeping records on all cases of discipline carried out by hospitals against doctors. To compound things more, the board is soon to license all physician assistants.

All these duties are heaped on the board and its original three-and-a-half-person staff, with no additional funds, space or personnel allocated.

"This is the bind the board, and indirectly the medical profession, is in," says Doctor Van Duyne. "These changes bring to the board an almost endless administrative load."

In addition, "there's a tremendous amount of misunderstanding on how the board should function and what its powers and limits are," observes Doctor Van Duyne, who succeeded C. Allen Payne, MD, Grand Rapids, as board president.

One of Doctor Van Duyne's major goals is to get more publicity for the board's challenges and problems. He is drawing up a statement of the board's purposes, problems and functions for presentation to any interested groups. He has begun appearances before county medical societies, but bemoans the board's lack of funds to communicate with doctors.

"I want the doctors to be informed that the board is not a threat. The only threat is the physician who is violating the Medical Practice Act.

He emphasizes that the state board is "not going to go out and randomly make investigations."

"The responsibility for finding the sick and incompetent doctors still rests with the community physicians." Doctor Van Duyne believes the state board's policing activities must be built on a solid foundation of local peer review. "There's no way the state board can say much about minimum standards without the local medical community having a review system functioning well enough to isolate these doctors," he says.

The state board's cases should come from the county society and hospital conduct committees, ethics committees, utilization review committees and the MSMS Judicial Commission, maintains Doctor Van Duyne. There should be a direct tie-in.

If it gets to the point the local groups can't do anything, they should then come to the State board with statements of the errant doctor's repeated violations and their own efforts to solve the problem — all documented well enough to hold up in a court of law.

"Doctors should become familiar enough with the licensing law to know when the 'bad apple' physician's activities are a violation of the medical practice law and they should know they can go one step further — to us," says Doctor Van Duyne.

"The problem is we now have the authority to remove the licenses of doctors for failure to live up to the standards of medical practice. With the malpractice crisis there is tremendous pressure to carry out the law. But we're short of money, we don't have the staff, and no filing system."

New Medical Practice Board Members

There are five new members of the influential Michigan Medical Practice Board, appointed Oct. 14 by Gov. William Milliken.

To enable Michigan doctors to better know the new members of the board, who will be overseeing much of their daily practices, the following resumes and photographs of the five are presented.

James C. Breneman, MD, Galesburg, a practicing allergist, will serve a term expiring Sept. 30, 1979. He is a member of the Kalamazoo Academy of Medicine, MSMS, the AMA, American Diabetes Association and New York Academy of Science. He is author of several scientific publications and recipient of the 1974 Enuresis Foundation Award.

Donald H. Kuiper, MD, Lansing, will serve a term expiring Sept. 30, 1979. Doctor Kuiper is director of medical education for St. Lawrence Hospital. He is a member of the MSMS Committee on Cancer, the American Gastroenterological Association, and the Michigan Association of Medical Education.

Osbie J. Herald, MD, Muskegon, succeeds the resigning H. Clay Tellman, MD, Muskegon, for the remainder of a term expiring Sept. 30, 1977. Doctor Herald practices family and emergency medicine. He is president-elect of the Muskegon County Medical Society, president of the Muskegon County Emergency Corporation, and chairman of the Muskegon County Medical Society Grievance Committee.

Carol E. Pearson, MD, Oak Park, will serve a term expiring Sept. 30, 1979. She has a private psychiatric practice and consulting office in Oak Park. She is a member of the Kingswood Hospital Board, a consultant at Lafayette Clinic, Wayne County Clinic for Child Study, Troy Schools and Lula Belle Stewart Center for Unwed Mothers. She is certified by the American Board of Psychiatry and Neurology, a community lecturer and is involved in various research programs.

Robert C. Prophater, MD, Bay City, will serve a term expiring Sept. 30, 1979. Doctor Prophater is past president of the Bay, Arenac, Iosco County Medical Society, charter member of the Michigan Association of the Professions, MSMS councilor, member of the board of directors of United Way, and member of the Bay Medical Center board of trustees.

Following is a list of the current members of the Michigan Medical Practice Board. The appointment year ends on September 30, and for Doctor Van Duyne, Doctor Moses, and Doctor Pillote it is 1977; for Mrs. Thoms, 1978: for all others it is 1979.

James. C. Breneman, MD, Galesburg
Osbie J. Herald, MD, Muskegon
Donald H. Kuiper, MD, Lansing
John W. Moses, MD, Southfield
Carol E. Pearson, MD, Oak Park
Florence Ann Pillote, MD, Marquette
Robert C. Prophater, MD, Bay City
Donato F. Sarapo, MD, Adrian
Mrs. Margaret Thoms, Birmingham
Frederick W. Van Duyne, MD, Flint
John R. Wilson, MD, Grand Rapids

The members each serve on committees, which are being emphasized by new board chairman Frederick Van Duyne, MD. Dividing the work load in an attempt to make it more manageable, will be the following committee members.

Physicians' Assistants, Continuing Medical Education and FLEX — Doctors Moses, Breneman and Sarapo

Investigations — Doctors Wilson, Pearson and Herald

Budget and Legislation — Mrs. Thoms and Doctor Prophater

Office Procedures — Doctors Kuiper and Pillote

Boards' New Director Reflects On First Few Months On Job

Mr. Brennan

The enthusiasm of the "new" Michigan Medical Practice Board, (with its five fledgling members) "knows no end," according to Executive Director Bert Brennan. "If their enthusiasm continues, they're going to be an extremely active and effective board."

Mr. Brennan, who was appointed as executive director in May to succeed the late John N. Wellman, MD, was reflecting on his six months on the job and looking ahead to the board's future.

"Doctor Van Duyne (Frederick W., new board chairman) is articulate and willing to work. The presidency of the board is a large undertaking with all the implications of the new laws being tossed at us. He's going to have a terrific time adjusting his schedule and keeping up with the pace Doctor Payne (previous chairman, C. Allen) sets."

What was the governor's intention in replacing so many former board members at one time?

"I haven't any idea what rationale he used to supplant these people. His office did not say why. Politics usually has something to do with appointments of this type, and I have to assume some of the new appointees made some political input to further their appointments." (Other insiders have speculated that the governor was not happy with the pressure the former board leaders were exerting to secure more money for the board.)

How do you feel personally after six months on the job?

"There's constant challenge in this job. The Medical Practice Board used to have two or three cases per year, and went along low key, giving exams. Now, all of a sudden, the spotlight is on it."

I see our major challenges as making the laws they've given us work. If we can tighten the standards of medical care, we'll be doing a good job."

How can the board get more funds and staff, two dire needs?

"We have to keep crying wolf. I think we're reaching ears in the legislature and they're the only ones who can appropriate the money. I think the board tried to go along doing its best in the past until it got backed into this corner and it's come out fighting."

What can Michigan MDs do to help?

"Start knowing who their legislators are, to bring our story back to the legislators who represent them. The doctors back home can be a tremendous force — they have great influence with many people."

How would you answer the critical persons who say the board's executive director should be an MD, not a layman as you are?

"I have to assume from reactions of medical practitioners and board members that they've accepted me. The reactions against me as a non-MD have been almost nil.

"I believe I can provide very good support for the board with my experience in the health care field as a pharmacist and my legislative background.

"I've tried to weld a happier operation. With my ties in the legislature, I've bent a few ears. Now they're listening more, where before they just said, 'Aw, the hell with you, everybody wants more money.'

"I've tried to keep a good working relationship with MSMS, the other boards and the L and R Department. I hope I've brought a new breath of air to the board. I've tried."

(Mr. Brennan is a pharmacist with a BS degree from Ferris State College, served three terms in the Michigan House as representative from Saginaw. He was Republican House Whip, and sponsored The Controlled Substance (Drug Abuse) Act.)

Proposed Bill Would Add More Lay Members to Board

The full Michigan House of Representatives is now considering HB 4804, which would increase from one to three the number of public members on the Medical Practice Board, mandate a central "historical record" of each Michigan physician, and establish formulas to increase re-registration fees whenever allocations to the board exceed 70 percent of monies accrued by the board. The bill earlier passed the House Committee on Public Health.

MSMS has testified against the addition of public members to the board, questioning whether three public members rather than the one present lay member will make the board three times as open to the public. The Medical Practice Board has testified against the bill as over-burdening.

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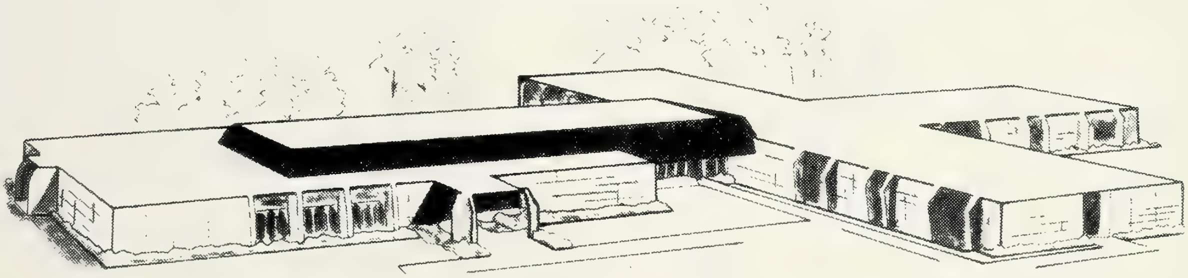

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Here's a Rundown On Current Licensing Rules

"What are the procedures that must be followed now for someone to obtain a Michigan license to practice medicine?"

"Is an internship still required?"

"Tell me about the ECFMG examination for foreign-trained doctors?"

Those are some of the questions that come into MSMS regularly from physicians, medical students and others.

So, here are the answers in a concise outline form for review and to share with others . . .

I. Re Graduates of American Medical Schools:

A. The medical student upon completion of medical school, receives a MD degree from the medical school. This degree alone does not permit him or her to practice medicine.

B. The Michigan Medical Practice Act requires that an applicant for a license must be a graduate of a medical college and must have completed one year of postgraduate medical education at an approved hospital. That one year may be part of a longer residency training program. The old one-year "internship" does not exist as such any more.

C. The Michigan Medical Practice Board issues a "temporary license" to the medical school graduate during his first year of postgraduate education.

D. The new doctor who wants to practice in Michigan must pass either the "National Boards" examination or the "FLEX." The "National Boards" is administered by the National Board of Medical Examiners at medical school locations. The FLEX is a project of the Federation of State Licensing Boards of the United States. The letters "FLEX" stand for Federation Licensing Examination.

E. The Michigan Medical Practice Board offers the FLEX twice each year. The examination is divided into three parts. An applicant for a Michigan license may take one or two parts of the test over a second time, but if he fails one part a second time, he then must take the entire test over.

F. Physicians who hold licenses in other states may apply for a Michigan license through reciprocity. Certain provisions must be met.

II. Re Graduates of Foreign Medical Schools:

A. Graduates of foreign medical schools must take the ECFMG examination before they can begin to qualify for a Michigan license to practice medicine. The ECFMG examination is a project of the Education Council for Foreign Medical Graduates, which is sponsored by the AMA, American Hospital Association, Association of American Colleges, Association for Hospital and Medical Education, and the Federation of State Medical Boards of the United States. (Graduates of Canadian or Puerto Rican medical schools are not required to obtain certification from ECFMG because Canadian medical schools are accredited by the Liaison Committee on Medical Education, just as are the medical schools in the U.S. and Puerto Rico.

B. The ECFMG examination is given twice each year at various locations across the nation and around the world. The Michigan center is at Ann Arbor.

C. The examination is divided into two parts, a medical part and an English part. The candidate may take either part over if he or she fails to get a passing grade.

D. Once the foreign medical graduate has passed the ECFMG, then he must go through the same Michigan licensing procedures that graduates of American, Canadian & Puerto Rican medical schools must complete — one year of postgraduate training at an approved hospital and then a passing grade on the National Boards or the FLEX.

State Board Requires Display Of License

Are you displaying in your office your Michigan license to practice and your annual re-registration certificate?

The State Medical Practice Board urges all physicians to do so. When the Board sent to every physician his or her application for re-registration, that instruction was given on the attached memo that may have been accidently misplaced.

The State Board declared:

"Your license to practice and your annual re-registration certificate should be prominently displayed in your place of practice."

The State Board also told every doctor:

"All registrants are further reminded that stationery, telephone and other listings should use your name only as shown on your license to practice with the latest address of your practice office as indicated on the annual re-registration certificate. Any change in spelling, abbreviation or other changes in name or failure to use proper address may be considered a violation of the rules and regulations of the Michigan Medical Practice Act."

No. 3
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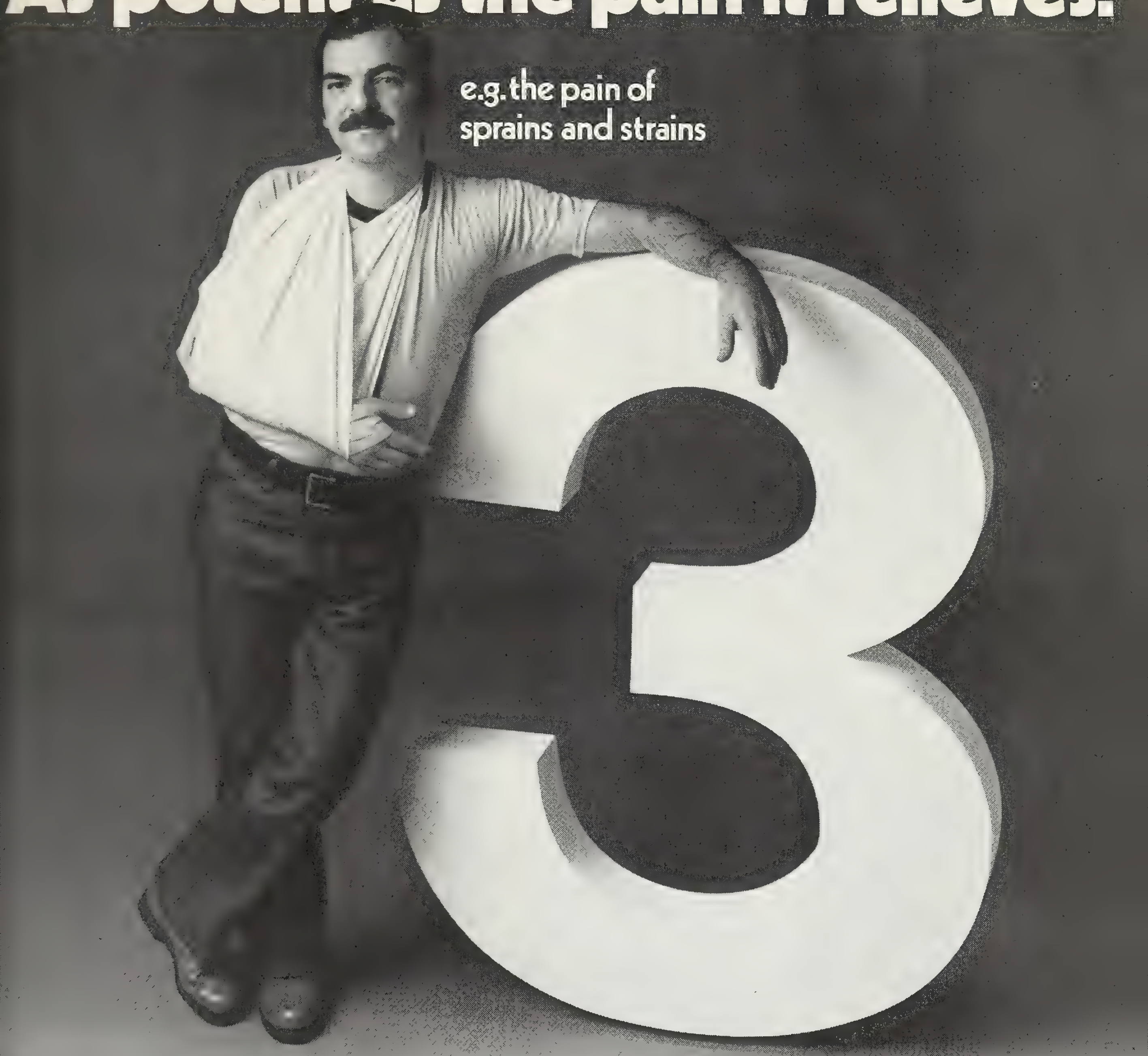

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Effectiveness across the spectrum of most common forms of insomnia

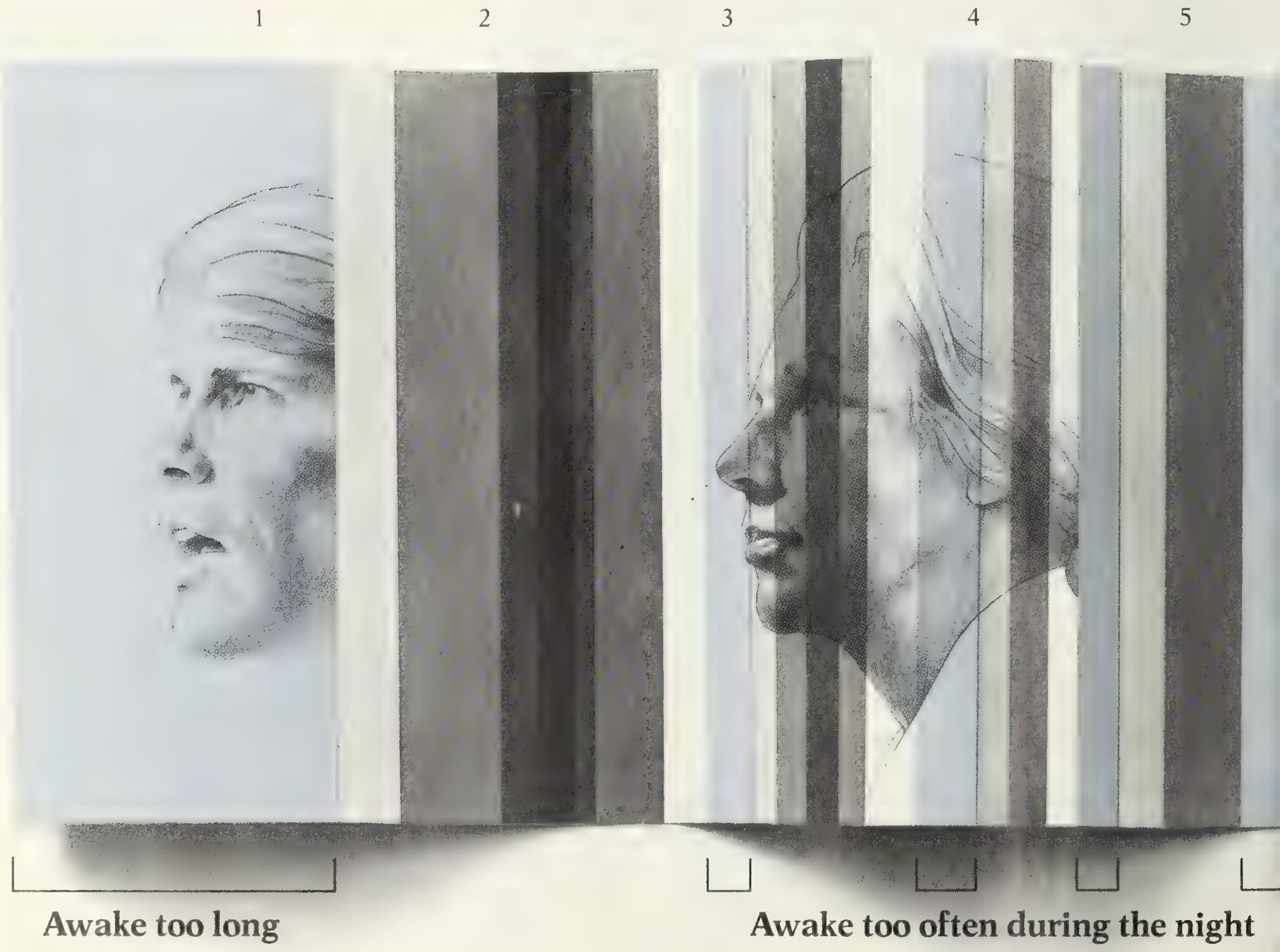
Awake too long, awake too often, awake too early…

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

□ Awake
□ REM
□ Stage 1
▨ Stage 2
▩ Stage 3
■ Stage 4


1
2
3
4
5
Awake too long
Awake too often during the night

The insomnias most often occurring in young and older adults

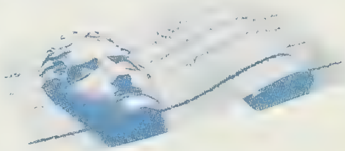
For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories.[1-4]

The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

7
Hours
Awake too early

Broad-spectrum medication for the most common forms of insomnia



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

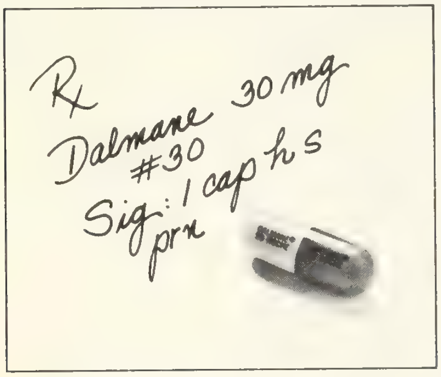
☐ induces sleep rapidly
☐ reduces nighttime awakenings
☐ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) ⓒⅣ



Objectively proved in the sleep research laboratory, Dalmane

- ☐ induces sleep within 17 minutes, on average
- ☐ reduces nighttime awakenings
- ☐ provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum benefic effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medica Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

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A Word to the Wise Physician: Health Service Areas are Coming!

By Herbert A. Auer, Manager, MSMS Communications Department

One of the interesting 1976 developments for Michigan doctors to watch — and try to influence — will be the formation of Health Systems Agencies within the eight designated Health Service Areas of the state.

Across the nation 200 Health Systems Agencies are being established under the provision of the National Health Planning and Resources Development Act of 1974, PL93-641.

HSAs to be Far-Reaching

The provisions of that law as it can affect medical and health care can be far-reaching. The federal act provides for Health Systems Agencies to be responsible for health planning and development.

The Health Resources Administration of HEW puts it this way, "The HSA will be generally responsible for preparing and implementing plans designed to improve the health of the residents of its health service area; to increase the accessibility, acceptability, continuity, and quality of health services in the area; to restrain increases in the cost of providing health services, and to prevent unnecessary duplication of health resources."

The new national law also provides for one statewide agency and Governor Milliken has so designated the Office of Health and Medical Affairs. That office, which has been the health planning agency since 1972, now "will assume new and expanded responsibilities under the federal law," according to Governor Milliken. That office is part of the Department of Management and Budget.

MSMS has worked closely with OHMA on many matters. Donald C. Smith, MD, formerly head of the office, is now the director of the State Department of Mental Health. Jay G. Endsley, now the director of OHMA, spoke at the 1975 MSMS Scientific Meeting.

In each area of the state there is to be designated by the Secretary of HEW, after consulting with the Governor, either a private, non-profit corporation or a public entity as the Health Systems Agency (HSA) to be responsible for health planning and development in that area.

Existing Comprehensive Health Planning Boards are already in the process of organizing new governing boards to meet the new law.

The law specifies that "each HSA must have a governing board of 10 to 30 members, the majority of whom must be consumers and the remainder providers."

It appears as though there will be quite a shake-up in some areas.

The Secretary of HEW is supposed to designate all 200 HSAs across the nation by July, 1976 but many observers feel the deadline will not be met.

The HSAs' Powers

The powers of the HSAs will be very comprehensive. HEW publications itemize these activities for HSAs:

"1. Gather and analyze data;

"2. Establish health systems plans (HSPs) — plans and statements of goals and longterm objectives — and annual implementation plans (AIPs);

"3. Provide technical and/or limited financial assistance to organizations seeking to implement the plans;

"4. Coordinate activities with PSROs and appropriate planning and regulatory entities;

"5. Review and approve or disapprove applications for Federal funds for health programs within the health service areas;

"6. Assist States in the review of capital expenditures proposed by health care facilities within their health service area;

"7. Assist States in making findings on the need for new institutional health services proposed for the area;

"8. Assist States in reviewing the appropriateness of existing institutional health services offered in the health service area and

"9. Annually recommend to States projects for modernizing, constructing and converting health facilities in the area."

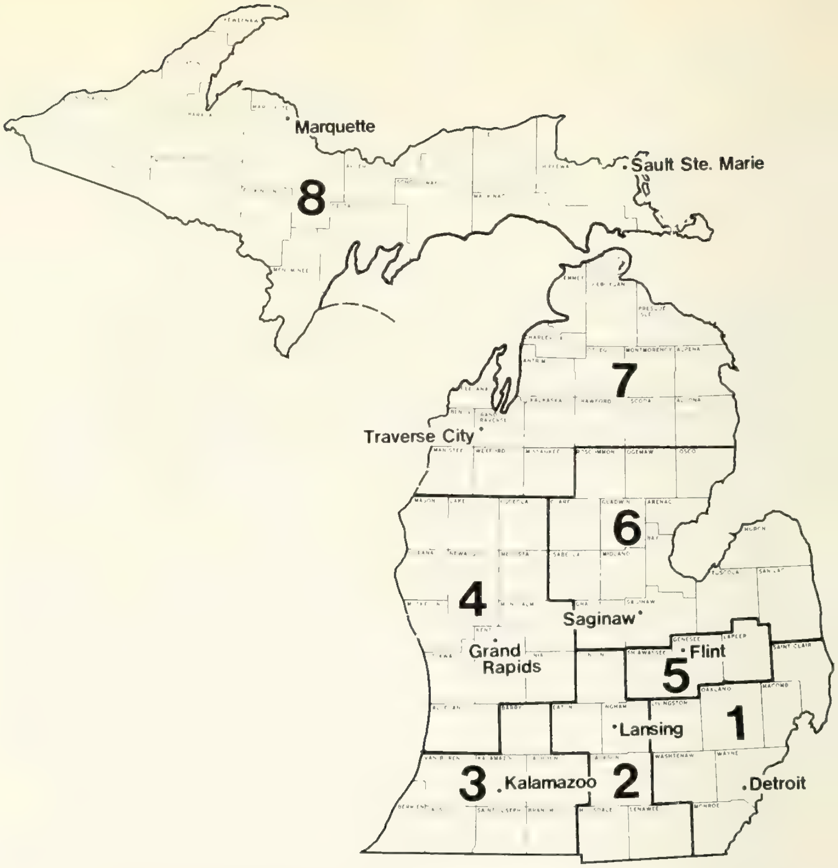
Hand-in-hand with the law that requires such HSA activities there will be considerable money available for staff, study and programming.

"Fully designated HSAs are eligible to receive Area Health Services Development funds in the amount of $1 per capita for the health service area. These funds may be used by the HSA to make grants or contracts for health service development projects which advance the goals enunciated in the Agency's HSP and AIP. The funds may not be used for the actual delivery of health services," according to HEW.

Grants, of course, are subject to the annual appropriations of funds by Congress. Lack of adequate appropriations has been described as a major problem in funding area PSROs.

Applications for HSA designation and funding may be obtained by interested Michigan leaders from the Region V office of Health, Education & Welfare, at 300 S. Wacker Drive, Chicago, Illinois 60606.

(This article is the first planned in Michigan Medicine *to alert Michigan doctors to the implications of the looming and powerful HEW Health Service Areas. Views will be provided in the February issue of* Michigan Medicine *by James D. Fryfogle, MD, Southfield.)*



This map shows the eight Health Service Areas designated for Michigan. The new boundaries combine four of the former Areawide Comprehensive Health Planning Regions in southwestern and southcentral Michigan into two HSAs. HSA #3 now includes former comprehensive health regions #3 and #4, and HSA #2 includes former comprehensive health regions #2 and #6. The other areas remain unchanged.

Negotiations Seminar At Hillsdale

MSMS members interested in participating in the AMA Seminar on Negotiations at Hillsdale College April 26-30 may obtain details from James H. Sammons, MD, Executive Vice President, AMA, 535 N. Dearborn, Chicago 60610. Registration will be limited to 30. The seminar fee, including housing and meals, will be $750.

The AMA Department of Negotiations recently announced the seminar at Hillsdale and one for Albuquerque Feb. 16-20.

Michigan Hospital Statistics

Here are some interesting facts from the Michigan Hospital Association's Summary of State Tabulations for Michigan in 1974:

	Michigan	**U.S.A.**
Total hospitals	255	7,174
Beds	65,317	1,512,684
Patient admissions	1,415,407	35,506,190
Average daily census	44,353	1,167,353
Total operating expense	$1,845,178,000	$41,406,109,000
Payroll expense	$1,654,291,000	$23,820,862,000
Total personnel (Full Time Equivalent)	120,107	2,918,736
Total Community Hospitals*	209	5,875
Beds	38,075	925,996
Average daily census	30,431	699,687
Patient admissions	1,353,555	32,865,867
Payroll expense	$ 867,844,000	$17,767,244,000
Total operating expense	$1,563,195,000	$32,616,697,000

*Community hospitals are defined as nonfederal short term general and other special hospitals exclusive of units of institutions.

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MEETINGS

Jan. 19-23 – Family Practice Review I, cosponsored by Michigan Academy of Family Physicians, at Towsley Center, University of Michigan Medical Center*

Jan. 21 – MSMS Council, at MSMS Headquarters, contact: Warren F. Tryloff, director

Jan. 23-25 – AMA National Leadership Conference, Marriott Motor Hotel, Chicago, contact: James Rosevear, 535 N. Dearborn, Chicago, Illinois 60610

Jan. 25-30 – Second Winter Midwest Institute on Alcohol Studies, Eastern Michigan University, Ypsilanti, contact: John Cook, chief, Information and Education, Michigan Department of Public Health, 3500 N. Logan, Lansing

Jan. 26-30 – Family Practice Review II, cosponsored by the Michigan Academy of Family Physicians, at Towsley Center, University of Michigan Medical Center*

Jan. 28 – Workshop on Borderline States, sponsored by Michigan Psychiatric Society, Wayne County Medical Society's David Whitney House, 1010 Antietam, Detroit, contact: Helen Schulte, MSMS Headquarters

Feb. 10-17 – Medical Specialty Review Seminar, Snowmass-at-Aspen, sponsored by Leonard Wolin, MD, contact: Doctor Wolin, 2216 Medford Road, Ann Arbor 48104

Feb. 14 – February seminar, Michigan Society of Pathologists, Henry Ford Hospital, contact: Jacob E. Briski, MD, Department of Pathology, St. John Hospital, Detroit 48236.

Feb. 19 – February meeting, "Genetic Aspects of Autoimmune Disease," Michigan Allergy Society, at Mercy College of Detroit, contact: B. David Wilson, MD, secretary, MAS, 4615 W. Main St., Kalamazoo 49007

Feb. 23-27 – Postgraduate course, "Emergency Medicine," cosponsored by American College of Emergency Medicine, at Towsley Center, University of Michigan Medical Center*

Feb. 27-29 – Winter Meeting, "Prevention in Psychiatry: Do You Have To Get Worse Before You Get Better?" sponsored by Michigan Psychiatric Society, Hyatt Regency Hotel, Dearborn, contact: Helen Schulte, MSMS headquarters

March 3-4 – Postgraduate course, "Advances in Pediatrics," cosponsored by the Michigan chapter, American Association of Pediatri-

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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cians, at Towsley Center, University of Michigan Medical Center*

March 15-16 – Postgraduate course, "Oncology for the Practicing Surgeon," Towsley Center, University of Michigan Medical Center*

March 17 – The Council, MSMS headquarters, contact: Warren F. Tryloff, director

March 24 – March meeting, "Insulin Allergy," Michigan Allergy Society, at The Lion's Den, Lansing, contact: B. David Wilson, MD, MAS secretary, 4615 W. Main St., Kalamazoo 49007

March 24-25 – Annual Michigan Conference on Maternal and Perinatal Health, at Kalamazoo Center Inn, Kalamazoo, contact: Herb Auer, MSMS headquarters

March 29-31 – Postgraduate course, "Human Allergy: Management and Its Basis," for internists, at Towsley Center, University of Michigan Medical Center*

April 1 – 1976 Michigan Conference on Medical Aspects of Organized Athletics, at Long's Convention Center, Lansing, contact: Herb Auer, MSMS headquarters

April 3-4 – AMA Detroit regional continuing medical education meeting, Michigan Inn, Southfield, contact: William L. Simpson, MD, director, Continuing Medical Education, Wayne State University, Scott Hall, 540 E. Canfield, Detroit 48201

April 8-10 – Postgraduate course on medical otolaryngology, presented by MSU Department of Otolaryngology, at Kellogg Center, East Lansing, contact: Richard E. Hansen, MSU Department of Information Services, East Lansing 48824

April 11-12 – AMA-AMPAC Public Affairs Workshop, Shoreham Hotel, Washington, D.C., contact: John Richards, MSMS headquarters

April 12 – Annual MDPAC-Congressional Reception, Capitol Hill Club, Washington, D.C., contact: John Richards, MSMS headquarters

April 30-May 2 – MSMS House of Delegates, Troy Hilton, contact: Richard Campau, MSMS headquarters

April 30 and May 2 – The Council, Troy Hilton, contact: Warren Tryloff, director

May 4 – Michigan Cancer Coordinating Committee meeting, MSMS Headquarters, contact: Helen Schulte, MSMS headquarters

May 19 – Annual meeting, Michigan Allergy Society, contact: B. David Wilson, MD, secretary, MAS, 4615 W. Main St., Kalamazoo 49007

May 19 – 108th Annual WSU Medical Alumni Reunion Day, Michigan Inn, Southfield, contact: WSU University Relations-School of Medicine, 540 E. Canfield, Detroit, 48201 (313) 577-1495

June 2-4 – Annual meeting, Michigan Public Health Association, Grand Hotel, Mackinac Island, contact: LaRue Miller, executive director, MPHA, 403 Seymour, Lansing

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*Contact Robert K. Richards, Towsley Center, University of Michigan, Ann Arbor 48104

Anabolic Stimulant Increased Muscular Tone Osteoporosis

EACH ANDROID-G TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg
Methyltestosterone	1.25 mg
L-lysine	100 mg
Nicotinic Acid	12.5 mg
Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide	0.075 mg
Calcium (from Dicalcium Phosphate	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

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Beverly C. Payne, MD,
Assistant Dean,
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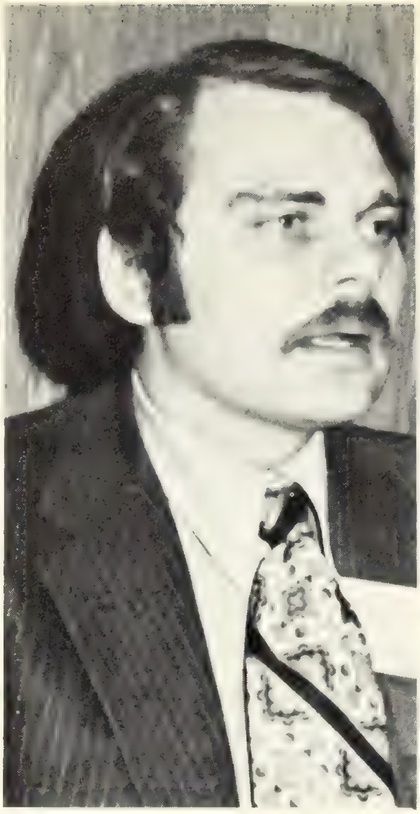
U-M School of Medicine



Albert C. Stolper,
Project Manager,
AMA Criteria
Development Project
Chicago

William Jessee, MD,
Special Assistant
to the Director,
HEW Bureau
of Quality Assurance
Washington, DC

First PSRO Workshop An SRO Event

On November 19 the Michigan PSRO Support Center conducted a workshop entitled "Admissions Certification and Continued Stay Review — From Principles to Practice." This was the first in a series of such PSRO meetings planned by the Center for the next few months.

Response to the workshop was overwhelming. The 275 registrants attending the one-day session held at the Detroit Metropolitan Airport Hotel included 60 physicians, representatives from 100 Michigan hospitals, persons from every Michigan PSRO area, and out-of-state attendees from Illinois, Indiana, and Minnesota. Due to space limitations another 100 applicants were rejected.

The 12-member faculty for the session included Alvin Ankrum, executive director, Baltimore City PSRO; Donald Blass, executive director, Professional Review Organization, GLSC, and members of his staff; William Boyles, Blue Cross/Blue Shield of Michigan; James Groen, Michigan Department of Social Services; William Jessee, MD, special assistant to the director, Bureau of Quality Assurance; Beverly Payne, MD, assistant dean, University of Michigan Medical School; Jack Perlman, MD, Commission on Professional and Hospital Activities; David Putman, American Health Systems; and Albert Stolper, Project Manager, American Medical Association Criteria Project.

Highlights of the program included remarks by HEW's Doctor Jessee concerning the status nationally of the PSRO program, a demonstration of the concurrent review process by Mr. Blass and the staff of the Flint PSRO, presentations on the development and use of screening criteria by Doctor Payne and Mr. Stolper, and an explanation by Mr. Ankrum of the issues at stake in deciding whether or not review authority should be delegated by the PSRO to hospitals. Messrs. Boyles, Groen, Putman, and Doctor Perlman outlined the relationships of their respective organizations to the PSRO program.

The highly successful Support Center workshop was planned and conducted in cooperation with the MSMS Ad Hoc Committee on Peer Review Systems chaired by Kenneth Ray, MD. The Center has been operated by MSMS under contract with the U.S. Department of Health, Education, and Welfare since July 1, 1974.

Interest ran so high in the first PSRO workshop sponsored by the Michigan PSRO Support Center that approximately 100 persons had to be turned away from registration. Future workshops are planned by the Support Center on various aspects of PSRO operation. to accommodate the high interest around the state.

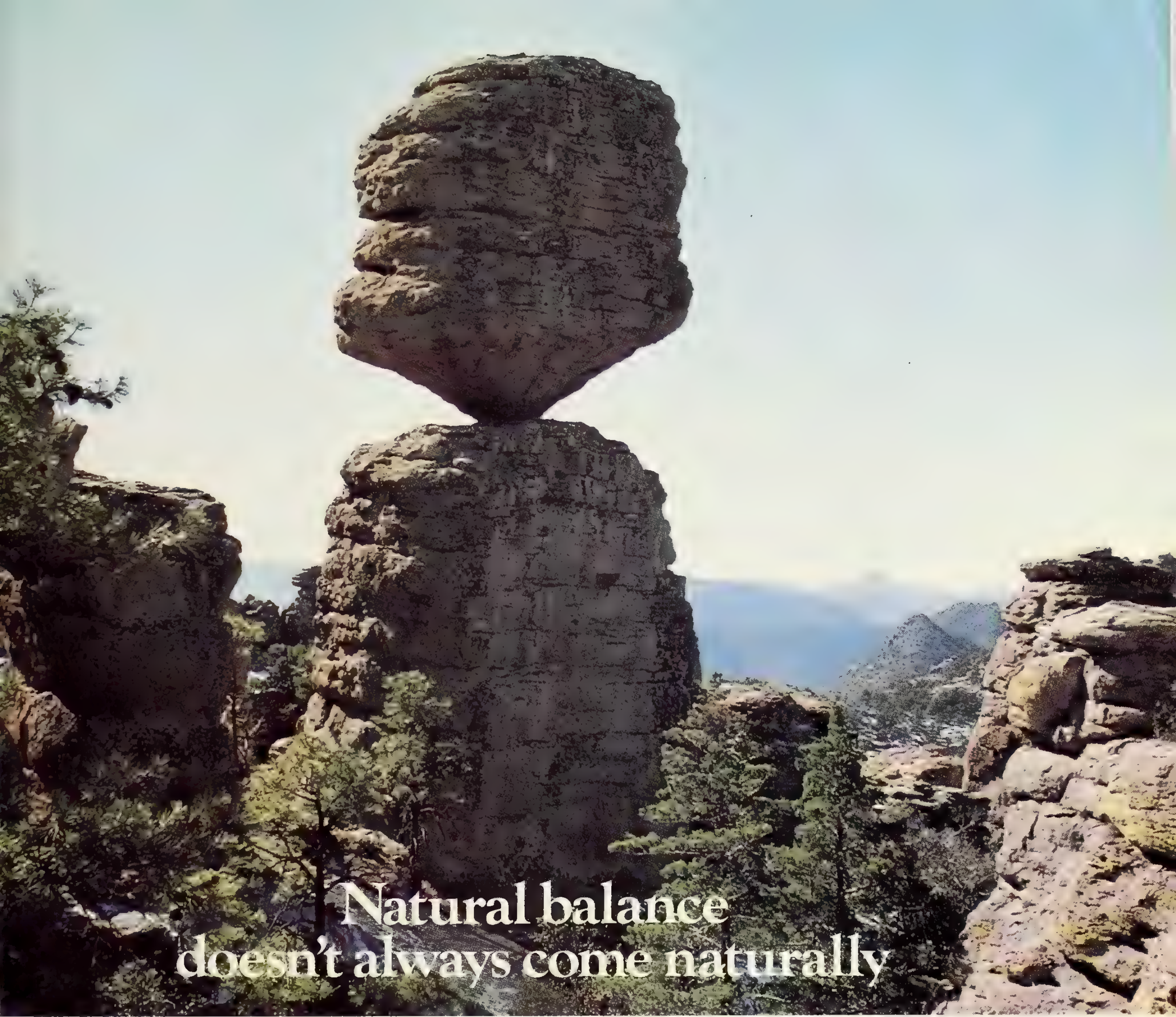
Herb Mehler, left, project director, Michigan PSRO Support Center, and Alvin D. Ankrum, executive director, Baltimore City PSRO, afternoon speaker during the workshop.

Kenneth J. Ray, MD, left, chairman, MSMS Ad Hoc Committee on Peer Review Systems, and James C. Morant, Washington, DC, PSRO project officer, HEW Region V, Bureau of Quality Assurance.

SHERWOOD
Ms TRUSELL

Panel members from the Professional Review Organization – Genesee, Lapeer, Shiawassee Counties, from left: Janet Sherwood, RN, review coordinator; Donald Blass, executive director; Cynthia Trusell, RN, review coordinator, and James Burns, assistant executive director.

Members and guests of the MSMS Ad hoc Committee on Peer Review Systems, from left around the table, James C. Morant, Washington, DC, PSRO project officer, HEW Region V, Bureau of Quality Assurance; Phillip Stott, MD, Kalamazoo, chairman, Michigan Area 10 PSRO Steering Group; Harold Falls, MD, Ann Arbor, ad hoc committee member; Ezra V. Bridge, MD, Port Huron, chairman, Area IV PSRO of Michigan; Phillip Richards, MD, Jackson, chairman, Area VII PSRO; Carl Van Appledorn, MD, Ypsilanti, ad hoc committee member, and William Jessee, MD, special assistant to the director, HEW Bureau of Quality Assurance.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

ound useful in the management of vertigo* associated with
eases affecting the vestibular system.
an relieve nausea and vomiting often associated with vertigo.*
Jsual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
lso available as Antivert (meclizine HCl) 12.5 mg. scored
lets, for dosage convenience and flexibility.
ntivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for
isea, vomiting and dizziness associated with motion sickness.

F SUMMARY OF PRESCRIBING INFORMATION

NDICATIONS. Based on a review of this drug by the National Academy of iences—National Research Council and/or other information, FDA has classified e indications as follows:
Effective: Management of nausea and vomiting and dizziness associated with otion sickness.
Possibly Effective: Management of vertigo associated with diseases affecting the stibular system.
Final classification of the less than effective indications requires further vestigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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E-Mycin®
erythromycin enteric-coated tablets, Upjohn
250 mg
Formulated for quality...
Priced for economy.
Upjohn

See facing page for brief summary of prescribing information.

J-4889-9

MYCIN® TABLETS — 250 mg — For Oral Administration (eryromycin enteric-coated tablets, Upjohn)

Mycin Tablets (erythromycin enteric-coated tablets) are speally coated to protect the contents from the inactivating effects gastric acidity and to permit efficient absorption when adinistered either immediately after meals or when given beeen meals on an empty stomach.

dications: *Streptococcus pyogenes (group A beta-hemolytic reptococci):* Upper and lower respiratory-tract, skin, and softsue infections of mild to moderate severity. Parenteral benzaine penicillin G is considered by the American Heart Associan to be the drug of choice in the treatment and prevention streptococcal pharyngitis and in long-term prophylaxis of eumatic fever. When oral medication is necessary (because e parenteral route is contraindicated) or if there is known ergy to penicillin, the following recommendations made by e American Heart Association apply: 1) Oral penicillin G or V here no allergy exists)—This is the drug of choice. Give for minimum of 10 days; 2) Erythromycin—Give for a minimum 10 days. A few strains of streptococci resistant to erythroycin have been reported.

pha-hemolytic streptococci (virdans group): Short-term proylaxis against bacterial endocarditis prior to dental or other erative procedures in patients with a history of rheumatic ver or congenital heart disease who are hypersensitive to nicillin. (Erythromycin is not suitable prior to genitourinary rgery where the organisms likely to lead to bacteremia are am-negative bacilli or the enterococcus group of streptococci.)

aphylococcus aureus: Acute infections of skin and soft tissue mild to moderate severity. Resistance may develop during eatment.

plococcus pneumoniae: Upper respiratory-tract infections g., otitis media, pharyngitis) and lower respiratory-tract intions (e.g., pneumonia) of mild to moderate degree.

coplasma pneumoniae (Eaton agent, PPLO): In the treatment primary atypical pneumonia, when due to this organism.

eponema pallidum: Infections due to this organism.

Corynebacterium diphtheriae and *Corynebacterium minutissimum:* As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.

Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extra-enteric amebiasis requires treatment with other agents.

Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of non-susceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

Treatment of overdosage: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdosage should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug, in addition to all needed supportive measures.

How supplied: 250 mg—in bottles of 100 and in unit-dose packages of 100 enteric-coated tablets. Caution: Federal law prohibits dispensing without prescription.

For additional product information, consult the package insert or see your Upjohn Representative.

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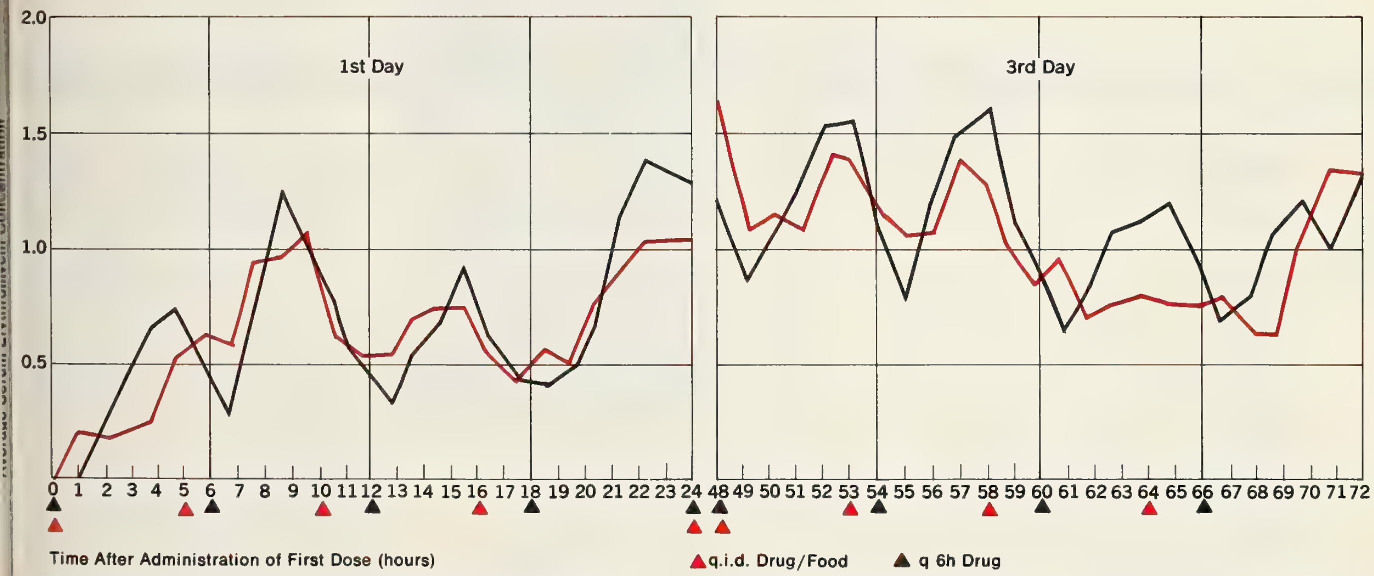
emonstrated bioequivalence of E-Mycin taken immediately after meals or between meals.



🟥 *Regimen A* (after meals)—One 250 mg E-Mycin® tablet administered q.i.d. immediately after breakfast, lunch, and dinner, and at bedtime with a snack.

■ *Regimen B* (between meals)—One 250 mg E-Mycin tablet administered q 6h at least two hours after meals.

E-Mycin Study CS076 on file at The Upjohn Company. The study was performed with twenty-two normal male adult volunteers utilizing a randomized two-way complete crossover design.

o statistically significant difference in area under e curve was observed from 0-24 hours or 48-72 urs at the 95% confidence level (p>.05).

e data clearly demonstrate that E-Mycin, when ministered q.i.d. immediately after meals, proced average serum levels equivalent to those tained when the drug was administered q 6h at st two hours after meals.

E-Mycin®

erythromycin enteric-coated tablets, Upjohn

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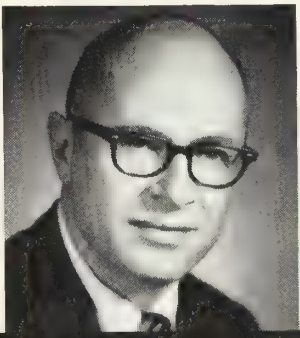
MED B-7-S

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?



Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

The idea of a so-called patien package insert has been around fo a long time. Many physicians alrea use written instruction sheets to provide patients with information about the drugs they are taking. Ar some physicians give verbal instru tions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit wit glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official packag insert for patients is a good one. Perhaps we should really think of this kind of information simply as a extension of drug labeling.

The benefits of patient involvement

Many physicians may not rea ize how frequently a patient obtain his drug information from Aunt Tillie or the next door neighbor. Ar this information is almost always bad or irrelevant to the case at har Furthermore, the incentive to go along with a prescribed program i slim if the only reading matter the patient receives, along with his pr scription, is a bill.

As an educator I am impress by the principle that the best way t get someone to do something is to involve him in the process. So the

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

I think there are advantages well as some real disadvantages i a patient package insert. When yo begin to use semi-medical or med cal terms to describe complicatio or possible sequelae of disease or treatment, you may frighten the p tient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a packa insert will probably give the patie better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligati to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should b warned of the possibility of seriou side reactions—to know what the real dangers are. But it doesn't d bit of good to indicate that a patie on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that frigh engendered by the insert may possibly outweigh the potential good iain purpose of drug information or the patient is to get his cooperaon in following a drug regimen.

reparation and distribution of atient drug information

We would hope to amass inforiation from physicians, medical ocieties, the pharmaceutical indusy and centers of medical learning. he ultimate responsibility for uniorm labeling must, however, rest ith the Food and Drug Administraon. There is nothing wrong with iis agency saying, "this informaon is generally agreed upon and ierefore it should be used," as long s our process for getting the inforiation is sound.

Distribution of the information a problem. In great measure it ould depend on the medication in uestion. For example, in the case an injectable long-acting progesrone, we would think it mandatory issue two separate leaflets—a iort one for the patient to read bere getting the first shot and a long ie to take home in order to make a ecision about continuing therapy. this case, the information might put directly on the package and t removable at all. But for a meditation like an antihistamine this formation might be issued sepately, thus giving the physician the tion of distribution. This could eserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

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ly the doctor can remove that fear 20 or 30 minutes of conversation.

I'm not suggesting that we thhold any information from the tient because, first of all, it would totally dishonest and secondly, it uld defeat the very purpose of the sert. I do think that a patient on the th control pill should know about e incidence of phlebothrombosis.

If you're going to tell a patient e incidence of serious adverse retions, then you have to tell him at a concerned medical decision s made to use a particular meditation in his situation after careful nsideration of the incidence of mplications or side effects.

notionally unstable patients pose a pecial problem

There are patients who, becuse of severe emotional problems, uld not handle the information ntained in a patient package int. Yet if we are going to have a ckage insert at all, we just can't ve two inserts. I think we might nply have to tell the families of se patients to remove the insert m the package.

gal implications of the patient ckage insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

Every Doctor's Practice To be Affected by PHSRP

By Merwyn Scholten, MSMS Communications

Possible re-examination and rate regulations and certainly stricter government controls lie ahead for physicians, hospitals and everyone in the health care system if all the recommendations of a special legislative commission are adopted into Michigan law in 1976.

We're referring to the Public Health Statute Revision Project (PHSRP) — a joint legislative-Governor's committee appointed in late 1974 to examine all of Michigan's more than 1,000 health laws and regulations. The group is nearing the completion of its work and will recommend a massive change to revise existing health laws into a single code.

In the executive order creating the commission last year, its responsibilities were spelled out as follows:

"The Commission shall be charged with advising the Governor and the Legislature in the preparation of a revision and codification of Michigan Public Health Statutes which shall include, but shall not be limited to, the following responsibilities:

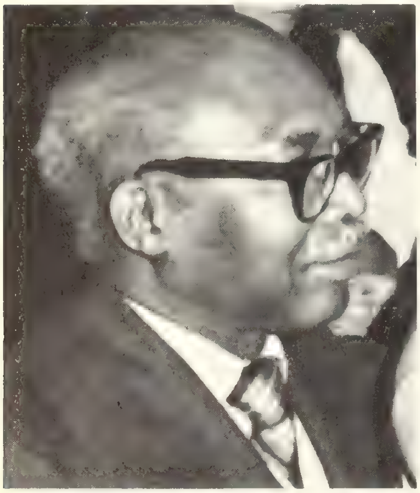
"1. To cooperate and work with the Legislative Council toward the common goal of developing a revision and codification of public health statutes.

"2. To advise and assist in the revision and codification of the Public Health Statutes in a manner which will provide for improvement in the effectiveness and efficiency of public health services delivered by state and local units of government to the people and communities of Michigan.

"3. To review existing federal health legislation with the objective of integrating federal standards and requirements in Michigan law, which are necessary to conform to national health mandates.

"4. To take cognizance of the important role and responsibility in health policy development of the Office of Health and Medical Affairs, Executive Office, and the State Health Planning Council, utilizing studies and guidelines prepared, or being prepared by those entities."

Twelve members, including two MSMS members, make up the commission. The two doctors are Addison E. Prince, MD, Detroit and Robert J. Toteff, MD, Saginaw. The rest of the members represent a wide spectrum of providers and consumers.


Doctor Prince

Doctor Toteff

MSMS Adds Views On PHSRP Proposals

After a full year of meetings, subcommittee study and a series of regional public hearings, the group prepared a list of 227 recommendations in its "Interim Report." Numerous health care provider groups including MSMS have been invited to give their reactions, comments, suggestions and objections to the interim report. The commission will weigh all the reactions before preparing the final legislative language to be presented to the Governor and legislature by March 1, 1976.

The MSMS Council last fall appointed an Ad Hoc Task Force on the Public Health Statutes Revision Project with James A. Read, MD, Oakland County, as chairman. Others serving on the task force are MSMS Councilors William A. DeYoung, MD and Thomas J. Setter, MD. Advisor to the task force is MSMS Past-President Otto K. Engelke, MD, and serving in ex-officio capacities are Robert J. Toteff, MD, and Addison Prince, MD, members of the PHSRP Commission. The task force has been asked "to closely monitor and interpret the project."

On Nov. 5, the MSMS Council received the task force report and accepted its recommendations.

On Nov. 25, The Council sent a letter to Governor William Milliken conveying its reactions to the PHSRP proposals. The letter says in part:

"The MSMS responses contained in this document (a copy of the ad hoc task force's report) are brief statements which serve to indicate

Doctor Read

those areas of most concern, or of lesser concern, at this time. Issues of most concern to MSMS will be elaborated upon in the next few months through a series of position papers. These will serve as the basis of MSMS action when the PHSRP recommendations reach the legislative arena."

The PHSRP recommendations contained in the Interim Report break down under six categories: administration; organizational resources; personal health services; manpower resources; environmental and occupational; data, research and development and health education.

MSMS Concerns Focus on Manpower Resources

While MSMS agrees with many of the PHSRP recommendations, The Council found numerous points of disagreement, particularly in the manpower resources section of the report.

Of particular concern is the suggestion calling for changes in the licensing of health care personnel. Many of the changes suggested have already been incorporated in the new medical practice act.

The task force raised a number of questions and concerns related to the whole manpower resources section stating that "MSMS is concerned that the issue of licensure is the only one being considered by the work group."

Among the license changes being discussed would be a call for periodic relicensing although the details of this have not been fully developed. Uppermost in the minds of physicians would be whether or not this "relicensing" would mean an actual re-examination for relicensure.

Early reaction to the initial proposal to create an actual rate-setting commission which, in essence, would have turned physicians and hospitals into a public utility was strong enough to cause the PHSRP group to modify its position. In the latest bulletin released by PHSRP the lead item explains:

"PHSRP will urge creation of a Health Cost Reimbursement Commission to make a four-year study of how the State can keep the lid on soaring health care costs.

"Noting that existing State rate regulation programs in Maryland and Massachusetts are sputtering, PHSRP's Organizational Resources Work Group recommended at the Nov. 10 PHSRP Project meeting *against* immediate creation of a Michigan rate regulation agency. (Emphasis is mine.)

"The PHSRP proposal is expected to call for a commission of full-time members appointed by the Governor and administratively centered either in the Department of Commerce's Insurance Bureau or the Department of Management and Budget."

In the November 25 letter to the Governor, The Council also noted that "MSMS has a general concern about the heavy reliance of PHSRP upon Public Law 93-641, the National Health Planning and Resources Development Act of 1974. While we concur that a Michigan Public Health Code must conform to relevant federal health laws, we seriously question the unlikely speculation that all the provisions of PL 93-641 are sufficiently clear."

Other items in the PHSRP report of special interest to physicians deal with allied personnel including nurses, physician assistants, midwives and emergency medical technicians.

While the MSMS task force offered comment on the expanded certificate of need provision and the plenary council within the Department of Licensing and Regulation to act as an ajudicature body, it was unable to make any definitive statement of position on the proposals concerning licensed private laboratories where more than three physicians are using the facility. The task force specifically recommended that this issue be referred to the MSMS Committee on State Legislation for analysis and The Council agreed as it said in the letter to the Governor, "The first issue we are addressing is the licensure of clinical laboratories. We believe that existing regulations need to be carefully analyzed and revised to insure quality and equity. Merely expanding the scope of current regulations does little to accomplish that goal."

While space does not permit listing all of the recommendations and responses individually, any MSMS member wishing to study the 227 PHSRP recommendations and the MSMS position on each of them may obtain a copy by writing to MSMS.

While there is general agreement that the massive task of recodifying the state's health laws needs to be done, MSMS leaders are urging all physicians to gather some basic understanding of the issues so that intelligent, honest input into the changes can be offered. While the changes will streamline the system, they have potential far-reaching effects on the practice of medicine and every physician has a stake in the outcome.

Governor Milliken urges citizen participation "either in person or through an organization reflecting your viewpoints." The Governor declares the project "will affect each and every one of us."

heartbeat

. . . a monthly column about physicians and others on the medical scene . . . what they're doing and where they're going . . .

Lee Stevenson, MD, Farmington obstetrician, spent a week in Moose Factory, Canada in December caring for mothers and newborns. This was the second year that Doctor Stevenson has served patients in the remote Canadian outpost at the southern tip of Hudson Bay. He recounted his experiences of the first visit in a series of *Detroit Medical News* articles last year.

Jerome Kozak, MD, Lansing orthopedic surgeon, left Michigan in December for Baytown, Texas where he will join a medical clinic group. Citing high malpractice insurance premiums as one of his prime reasons for the move, Doctor Kozak noted that his new premium in Texas would be approximately half of his current cost.

Another Lansing physician, **Henry Malcolm, MD,** left his obstetrical practice recently because of the high cost of malpractice insurance. He has moved to Florida.

L. Dell Henry, MD and Rhoda Powsner, MD, both of Ann Arbor, were honored by their colleagues in the Washtenaw County Medical Society last month. Both women received a certificate of commendation from the society for their "long-standing and outstanding service, not only to the medical community and their patients, but to medicine in the state of Michigan as well." Doctor Henry was a long-time Washtenaw representative to the MSMS House of Delegates and Doctor Powsner is currently serving as chairperson of the MSMS Committee to Implement Arbitration.

Moving from acting director to director of the Detroit Psychiatric Institute is **Lawrence E. Jackson, MD,** Detroit. A member of the staff of DPI for 15 years, Doctor Jackson has been acting director of the institute since last May. The permanent appointment was recently announced by Donald C. Smith, MD, director of the Michigan Department of Mental Health.

A former Wayne State University School of Medicine faculty member, **Hugh C. Hendrie, MD,** is the new chairman of the Department of Psychiatry at the Indiana University School of Medicine. He also serves as executive director of the Institute of Psychiatric Research at the university's Indianapolis medical center.

Marilyn Heins, MD, Associate Dean of the Wayne State University School of Medicine was one of three women honored recently as "Women in Education." She was presented with a scroll of the Women's Bill of Rights at a seminar on "Women and the Law" sponsored by the Women Lawyers Association and the Michigan Trial Lawyers Association.

Jack M. Stack, MD, Alma, **Brooker L. Masters, MD,** Fremont, and **Dean P. Carron, MD,** Ann Arbor, have been appointed to the new Mental Health Advisory Council by Gov. Milliken. The Council is charged with helping the Department of Mental Health develop and execute mental health policies and programs. Terms of the three expire Oct. 30, 1977. There are 12 Council members.

Appearing as guest panelists on the December "Housecall" television program on Channel 56, Detroit were: **Sue McCutcheon, MD,** Rochester; **Yvan Silva, MD,** Detroit, and **Robert Songe, MD,** Dearborn. They answered more than 30 questions on the air from among the 150 phoned in by viewers of the program.

Jay K. Harness, MD, director of health care for the Michigan prison system, is serving on an AMA advisory committee to improve medical care in jails. The initial task of the committee is to select six states to participate in a pilot project funded by the Law Enforcement Assistance Administration. More than 30 states have applied to take part in the program which will study current medical care standards in county and municipal jails, then draw up a set of minimum standards.

A November issue of the Journal of the American Medical Association carried an account of a presentation made by Detroit radiologist **John N. Wolfe, MD,** at a meeting of the American Roentgen Ray Society. The article details why Doctor Wolfe uses mammography to assess the risk of breast cancer.

Kim K. Lie, MD, Warren, was installed as President of the American Association for Hand Surgery at the Association's recent meeting in Toronto.

The Wayne State University Board of Governors has authorized establishment of the Allen Dee Health Care Centers Chair of Family Practice in the WSU School of Medicine. An endowment for this chair has been established through benefactions from **Paul L. Fraiberg, MD,** WSU medical alumnus, and the trustees of Elliott General Hospital. The contribution will be used to assist the WSU School of Medicine in its goal of increasing the role of family medicine in its teaching and training programs.

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MSMS Judicial Commission Studies, Acts on Vital Questions in '75

By John W. Grigg, MD, Chairman, Bay City

During the past year, the MSMS Judicial Commission has considered a number of problems. We believe the membership should be aware of the more important questions which have been studied by the Judicial Commission.

Nine Physicians Reprimanded Re Abortion Clinics

At the Judicial Commission's request, the Ethics Committee of Wayne County Medical Society investigated the physicians involved in the abortion clinics in Detroit. These came to our attention by Delores Katz's articles in the Detroit Free Press. After formal study and investigation, nine physicians were reprimanded.

In the past, in relationship to abortion clinics, component medical society ethics committees' and the Judicial Commission's activities have been limited to investigation of fee-splitting and improper advertising. Discipline is limited to censure, reprimand, suspension or expulsion from medical society membership. With the advent of PA106 (EHB4793) requiring the Michigan State Medical Society and component medical societies to report information relevant to disciplinary action to the State Licensing Board, more stringent measures may ensue from that Board.

AMA Judicial Council Stands Firm on Choice-Of-Patient Ethics

The Judicial Commission took note of the acute nature of the professional liability problem in Michigan; specifically, the ethics of refusing to treat emergency patients because of the fear of malpractice suits. Section 5, Article 1 of "Judicial Council Opinions and Reports" of the American Medical Association states:

"1. *Choice of Patient; Patient May Not Be Neglected*

"A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant."

After deliberation, the Judicial Commission suggested an amendment:

"It is believed that a physician should respond to any request for assistance in an emergency. However, in the light of present circumstances it is believed that, should society fail to provide an adequate opportunity for the physician to insure himself against alleged malpractice, or should the physician already insured be under the threat of cancellation of his insurance and thus a loss of his ability to carry on the practice of medicine should suit be brought, the physician may justifiably decline to render assistance on request."

After reviewing the suggested amendment, the AMA Judicial Council declined any change and stated they believed it was implicit that as the section is written, a physician may exercise judgment in the choice of patients. They further believed that physicians need not announce a reason for their selection or rejection.

With the establishment of the State Insurance Fund making available professional liability coverage to all physicians in the State, the question has become moot, at least for present.

Commission Rules Unethical To Charge to Complete Initial Insurance Form

Another matter which came to the Commission's attention involved physicians making a charge for completing standard medical forms. The AMA "Judicial Council Opinions and Reports" Section 7, Article 6, states:

Commissioners

Members of the Judicial Commission in 1975 were:

Sherman E. Andrews, MD, Kalamazoo; William C. Baum, MD, Holland; John W. Grigg, MD, Bay City; Clarence S. Livingood, MD, Grosse Pointe; John M. Malone, MD, Farmington; Joseph L. Ponka, MD, Detroit; Daniel L. Rousseau, MD, Mount Clemens; Justin L. Sleight, MD, Lansing; Robert K. Whiteley, MD, Grosse Pointe; George M. Wilson, MD, Marquette; and A. Stewart Kerr, Detroit, Advisor.

See related article for results of recent annual Judicial Commission election.

6. Billing for Completing Routine Health Insurance Claim Forms

"The attending physician should complete without charge the appropriate simplified Health Insurance Council forms approved by the Council on Medical Service, and similar insurance claim forms as a part of the physician's service to the patient to enable him to receive his benefits.

"A charge for more complex forms may be made in conformity with local custom. This suggestion is advisory. In all cases, the local medical society can be looked to for an authoritative opinion."

Section 7, Article 7 states:

"*7. Charge for Completing Multiple Insurance Forms*

"A statement of policy, by a group of physicians, reads: "Without charge we will fill out one insurance form. If you have more than one insurance company and bring all claim forms to our office at one time, they will be completed without charge. Should you bring additional forms for the same illness or injury at a later date, there will be an appropriate charge to be paid in advance." There is nothing improper in this practice. The ordinary needs of the patient are provided for without cost. Patient is advised of additional cost if additional work is imposed on the doctor's office staff."

The conflict in this instance arose because physicians were making a charge for the initial health insurance form. The intent of the above sections is clear.

It is the opinion of the Judicial Commission that billing the patient for filling out one initial insurance form is unethical.

Advises against Joining PC with Non-Physicians

An inquiry which involved considerable time and study, and we believe to be of paramount importance to the medical profession is whether it is ethical for physicians to join in the formation of a "mixed professional corporation." This involves the formation of a corporation by a physician with non-physician professionals, less qualified professionals, or paramedical professionals. The question originated from a psychiatrist and concerned the association of a psychiatrist, psychologist, and social workers in an outpatient clinic. Section 6 of "Opinions and Reports of the Judicial Council" of the AMA has a number of articles devoted to associations of physicians and other professionals. Section 6, Articles 14 and 15 apply most closely to the question.

"*14. Professional Association Laws*

The so-called "professional association laws" permit doctors to form professional associations. It was asked whether or not associations of doctors formed under this law would conform to the American Medical Association's Principles of Medical Ethics.

"In 1975 the House of Delegates of the Association declared that it is within the realm of ethical propriety for physicians to join together in partnerships, associations, or other lawful groups, provided that the ownership and the management of the affairs thereof remain in the hands of licensed physicians. In accordance with the policy of the House of Delegates, physicians may take advantage of "professional association laws" and may also ethically do those things which are necessary to reap the intended and proper advantage of such legislation."

Article 15 states:

"*15. Professional Corporations*

"If the laws of the state provide that physicians may organize professional service corporations for the practice of medicine, it is ethically permissible for physicians to form such corporations. It is implicit in such circumstances that the ownership and management of the affairs of the professional service corporation remain directly and solely under the control of licensed physicians, and that the attending physician remain responsible to his patient.

Doctor Grigg

"The ethical principles for the medical practice conducted under the form of a professional service corporation are exactly the same as for the individual physician. The professional service corporation and each physician member of the professional service corporation must observe and follow all the principles of medical ethics."

After study, the Judicial Commission believes that, while it may be legal, it is unethical for physicians to join in a professional corporation with non-physicians. It is entirely conceivable (in fact it has been brought to the attention of the Commission in a prior complaint) that a physician in such a corporation could retire, leave the community, or die. The non-professional involved in the corporation could continue the operation by hiring a physician. The non-professional as the director of the corporation would be the policy-maker. It is further conceivable that a physician under the circumstances could be placed in a compromising position. Also, a physician joining with non-professionals in a corporation could be out-voted by the non-professionals in policy making decisions and thus be compromised in

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regard to his professional judgment concerning the proper treatment and care of patients. For example, non-professionals might request or encourage the physicians to order more laboratory studies and x-rays solely to generate revenue.

The Judicial Commission agrees that ownership and management of a professional corporation must remain directly and solely under the control of a licensed physician. This opinion has been affirmed by the AMA Judicial Council.

Commission Believes Service By Physicians or Non-Professional Should Have Different Fees

Two other important questions were posed by a psychiatrist, but are also applicable to the entire profession. The questions were: (1) dividing fees paid by Blue Cross-Blue Shield between the employer (usually a psychiatrist) and the therapist-employee, and (2) charging the same fee to the patient or the insurance company whether the patient is treated by a physician, or by a less qualified professional or non-professional, such as a drug counselor or social worker. The questions were apparently raised because of the proliferation of Blue Cross-approved outpatient psychiatric facilities. The Michigan Psychiatric Society has proposed standards to discourage a number of abuses which have come to their attention. The Chairman of the Ethics Committee of the Michigan Psychiatric Society is of the opinion that dividing fees in the manner described is fee-splitting and therefore is unethical. Charging psychiatric fees for services performed by less qualified professionals or non-professionals is an excessive charge and is unethical. The Judicial Commission concurred with the Michigan Psychiatric Society that both practices are unethical. This is particularly true in the latter instance when the third party payer provides for a different reimbursement schedule for services performed by a physician and for services performed by non-physicians.

The Judicial Commission believes that the problem goes far beyond psychiatrists, psychologists, and social worker relationships, and can be applied to any physician association with less qualified professionals and non-professionals. The Commission is aware that "assumption of legal responsibilities for the service" is a frequently utilized device of justification; however, the Commission believes that when a non-professional or less qualified professional performs the same service that a qualified physician usually performs, the service should be billed at a different rate.

It is imperative also that the patient understands who has performed the service.

Not Ethical to Sell Records

A physician requested an opinion whether the sale of his medical records was ethical. The Judicial Commission after reviewing Section 9, Article 9 of the AMA "Judicial Council Opinions and Reports" was of the opinion that a physician may not ethically sell medical records.

Advice Given re 'Handling Fee' Charged by Lab

An apparent annual inquiry is the ethics of reimbursement to the physician for laboratory studies. In this instance there was an inquiry concerning a "handling fee" reimbursement to the physician by a laboratory. The Commission in previous rulings in 1972 and 1973 made it clear that this relationship is fee-splitting. A physician should bill the patient for his or her services, and the laboratory bill the patient for the performance of their services; i.e., if the physician does a venipuncture utilizing materials in his office, he should submit a bill to the patient. The laboratory should independently submit a bill to the patient for the performance of the test.

In exceptional cases where it is not possible for the laboratory bill to be sent directly to the patient, the physician's bill to the patient should implicitly indicate the charge for the laboratory service, the name of the physician director of the laboratory as well as the charges for the physician's services. We believe that physician's should be alert to various forms of subterfuge that in essence are fee-splitting, and therefore unethical.

Commission Conferring with Michigan Bell re Directories

For the past several years, MSMS, the Judicial Commission has been aware that Michigan Bell Telephone Company has expanded its directory listings to include regions, specialties, and subspecialties. We are aware that the American Medical Association does not consider it unethical for a physician to list his or her recognized specialty or subspecialty. The Judicial Commission is vitally concerned that individuals listed as specialists or subspecialists are bona fide.

Guidelines have been prepared by the AMA Judicial Council for telephone directory listings. A review of the AMA specialty and subspecialty list reveals a number of what might be described as dubious listings. These are so-called subspecialty listings which require little or not special training. If all of these are listed in the directory, there is no effective means of monitoring the physician who is licensed but not a medical society member, or member of a hospital staff (and perhaps expelled from membership for incompetence). Any physician can practice in an office and list himself as a hypnotist, weight reduction specialist, or others equally doubtful. Patients might consult these physicians in good faith because of the listing in the telephone directory. Proper treatment might be delayed with disastrous results.

Recognizing the necessity to establish a reasonable and responsible listing of specialties, and that some check on this problem is essential for the best public interest, a meeting with officials of Michigan Bell Telephone was requested by the Judicial Commission Chairman. This meeting was encouraged by the Public Service Commission. It occurred on November 13, 1975 with the following areas of tentative agreement.

1. The Judicial Commission at its December meeting will formulate an acceptable specialty and subspecialty list which Michigan Bell Telephone Company will follow rather than the present AMA lists.

2. Recognizing the difficulty of meeting publication deadlines, directory listings will not be sent to local medical societies for review before publication. Local medical societies are requested to review the directories as soon as possible to check the validity of the listings.

We were also informed by Michigan Bell officials that they have a continuing liaison with the Medical Practice Board to insure that only licensed physicians are listed in the directory.

The Judicial Commission in addition to establishing an acceptable listing of specialties and subspecialties for Michigan will request the AMA to again review carefully its own listings.

I wish to thank the component medical society ethics committees for their cooperation, my fellow members of the Commission for their decisiveness and resolution and the membership for giving me the opportunity to serve three years as Chairman of the Judicial Commission. It has been a rewarding experience.

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Indications: Treatment and prevention of potassium deficiency occurring especially during thiazide diuretic or corticosteroid therapy, digitalis intoxication, low dietary intake of potassium, or as a result of excessive vomiting and diarrhea and for correction of associated hypochloremic alkalosis.
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Adverse Reactions: Potassium intoxication indicated by listlessness, mental confusion, paresthesia of the extremities, weakness of the legs, flaccid paralysis, fall in blood pressure, cardiac depression, arrhythmias, arrest and heartblock. Vomiting, nausea, abdominal discomfort and diarrhea may occur.
Dosage and Administration:
One 15 ml. tablespoonful (20 meq. of potassium chloride) ***diluted*** in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician.
Overdosage: In case of excessive use resulting in hyperkalemia or potassium intoxication, discontinue use of potassium chloride administration or take other steps to lower serum levels if indicated.
How Supplied: Bottles of:
473 ml. . . . . NDC 0041-0145-16
3785 ml. . . . . NDC 0041-0145-28

145-8

Why 1976 AMA Dues are Higher

1976 county, MSMS and AMA dues billings are being received now by MSMS members. The billings reflect the increase in AMA dues to $250 voted by the AMA House of Delegates in its annual convention meeting last June.

The AMA delegates approved the dues increase to serve clear notice of a new and aggressive stance by the AMA in dealing with the many problems facing the nation's physicians.

By adopting the $250 dues level recommended by the AMA Board, the House voted to restore depleted AMA financial reserves, to continue strong programs such as those for malpractice, and to combat growing government intervention.

Let me urge each MSMS member to promptly remit his dues to county, state and national associations and thus continue the crucial work of our most effective and unified voice. In these days of big government, big business, big labor, we need a big voice, too. The AMA can provide it for us.

(To aid MSMS members in understanding the basis for the AMA dues increase, the following information is provided in question and answer form.)

—John J. Coury, Jr., MD
Chairman, Michigan Delegation to the AMA

FACT SHEET ON THE AMA DUES STRUCTURE FOR 1976

Q. Why did the AMA increase its dues?

A. The AMA was caught in an economic squeeze — the same kind of squeeze that nearly every individual, business, and organization has been faced with in recent years. Costs have risen. The AMA revenues have become inadequate to meet operating expenses. *The Association has operated at a deficit four of the past five years and reserves are insufficient to cover additional deficits.*

Q. How long has it been since the last dues increase?

A. *AMA dues have not increased since 1971,* but operating costs have soared.

Q. Was the membership alerted to the possibility of a dues increase?

A. Yes. In November, 1974 members of the AMA's House of Delegates, state medical associations, and medical specialty societies were notified of the existence of a "critical financial situation" and subsequently received additional background information on a proposed dues increase, the 1975 budget, a projection showing the effect of a proposed dues increase for 1975 to 1980, and reports on various aspects of the financial problem submitted by the Board of Trustees.

The general membership was informed by articles in *AM News* and the *AMA Newsletter.*

During the 1974 Clinical Convention the House of Delegates created a Special Committee of the House to review the priorities and financial capabilities of the organization with a report requested during the 1975 Annual Convention.

Q. Did the membership have an opportunity to present its views during the deliberations on the dues increase?

A. Yes. Each segment of the profession — general members, representative members, elected leaders, federation components, allied medical organizations, and staff — was afforded an opportunity to contribute to the review process and to the special committee's deliberations.

Q. What caused the financial problems identified in late 1974?

A. The financial problems were primarily due to:

1. Inadequate dues structure to support activities.
2. Marked reduction in cash reserves due to cumulative effects of deficit spending.
3. Overprojection of anticipated advertising revenues compared to income.
4. Acute cash flow deficiency in October and November of 1974 attributable to:
    a. Conversion of cash reserves into capital investments and fixed assets
    b. Adverse effects of simultaneously occurring inflation and recession
    c. Continued high expenditures for publications due to long lead time to effect reductions
    d. Customary end of year reductions in income.

Q. What has the AMA done to cut costs?

A. *Staff has been cut back by over 200 employees and publications costs have been reduced by 20%.* "A zero based" budget has been implemented which requires periodic rejustification of expenditures for every AMA activity.

Despite imposition of stringent financial constraints, expenditures continue to exceed income from all sources exclusive of income from the assessment instituted in 1975.

Q. How has the AMA used the money received from the special assessment?

A. The money generated from the assessment was used to repay short term bank loans of $3.0 million, for reserves for the projected $2.6 million 1975 deficit, and to reduce accounts payable by $1.3 million.

Q. What will the dues increase mean to the AMA?

A. The dues increase will currently assure a fiscally stable organization capable of aggressive action.

The dues increase will enable the AMA to:

1. Continue activities at the present dollar level;
2. Reexamine priorities and, depending on such review, restore some programs and initiate new ones to the extent of $2 million per year for the next few years;
3. Achieve a reserve fund of liquid assets equal to 60% of annual operating expenses within two years.

Q. Why is there a need for liquidity reserves?

A. It is urgent that the AMA's liquidity reserves be expanded quickly and substantially. The Board of Trustees and the AMA auditors are agreed that the Association's minimal liquidity reserves should be equal to 60% of its annual operating expenses. The establishment of a fund adequate to cover unforeseeable operating expenses and abnormal contingencies is a sound business practice.

Q. Why is the AMA considering new activities when they should be discontinuing programs in order to cut costs?

A. Both the House of Delegates and the membership at large have indicated that they do not want the AMA to become a static organization. The vote in the House to increase the dues showed that members of the House of Delegates want a strong, vigorous, financially healthy AMA. Therefore, the board has included in its projections an additional $1 million per year for newly budgeted programs.

Q. Will the dues increase cover the cost of high priority but unbudgetable activities?

A. Yes. The Board has added $1 million per year to operate the many high priority but unbudgetable activities, such as those that require legal action or sudden legislative effort, that must be conducted by the AMA if it is to remain in a leadership position. Governmental intervention through the use of rules-writing powers has grown at a rapid pace during the 1970-75 period, and the membership's rising demand for legal action is justified. The AMA went to court earlier this year and filed suit against HEW to prevent implementation of the UR regulation. In August, HEW said it will withdraw its UR regulations and will propose new language to replace the rules. The AMA is now in court against another set of regulations and one other law suit against federal regulations is now pending. The cost of these three law suits alone may total about $500,000.

Q. How much of the AMA's budget goes to support the AMA's lobbying effort?

A. The AMA is primarily a scientific organization. Despite the public media's attention to legislative activities, over 54% of AMA's budget is spent to improve the delivery of medical and health care; 12% to improve the quality of American medicine; 11% to improve the public's health knowledge and practices. Only about one-half of 1% is allocated to the Department of Congressional Relations (our lobbyists).

Michigan Doctors On National Boards

A number of Michigan physicians hold responsible positions in the various medical specialty boards, according to a review of the recent annual report of the American Board of Medical Specialties.

The following names of board officers are reported in alphabetical order, from allergy to urology:

Sidney Friedlaender, MD, Southfield, Secretary, American Board of Allergy and Immunology.

James A. Ferguson, MD, Grand Rapids, President; and Norman D. Nigro, MD, Secretary-Treasurer, American Board of Colon and Rectal Surgery.

E. Richard Harrell, MD, Ann Arbor, President; and Clarence S. Livingood, MD, Detroit, Executive Secretary, American Board of Dermatology.

Walter P. Work, MD, Secretary-Treasurer, American Board of Otolaryngology.

George H. Koepke, MD, Ann Arbor, Chairman, American Board of Physical Medicine and Rehabilitation.

Harold J. Magnuson, MD, Ann Arbor, Vice-Chairman Occupational Medicine, American Board of Preventive Medicine.

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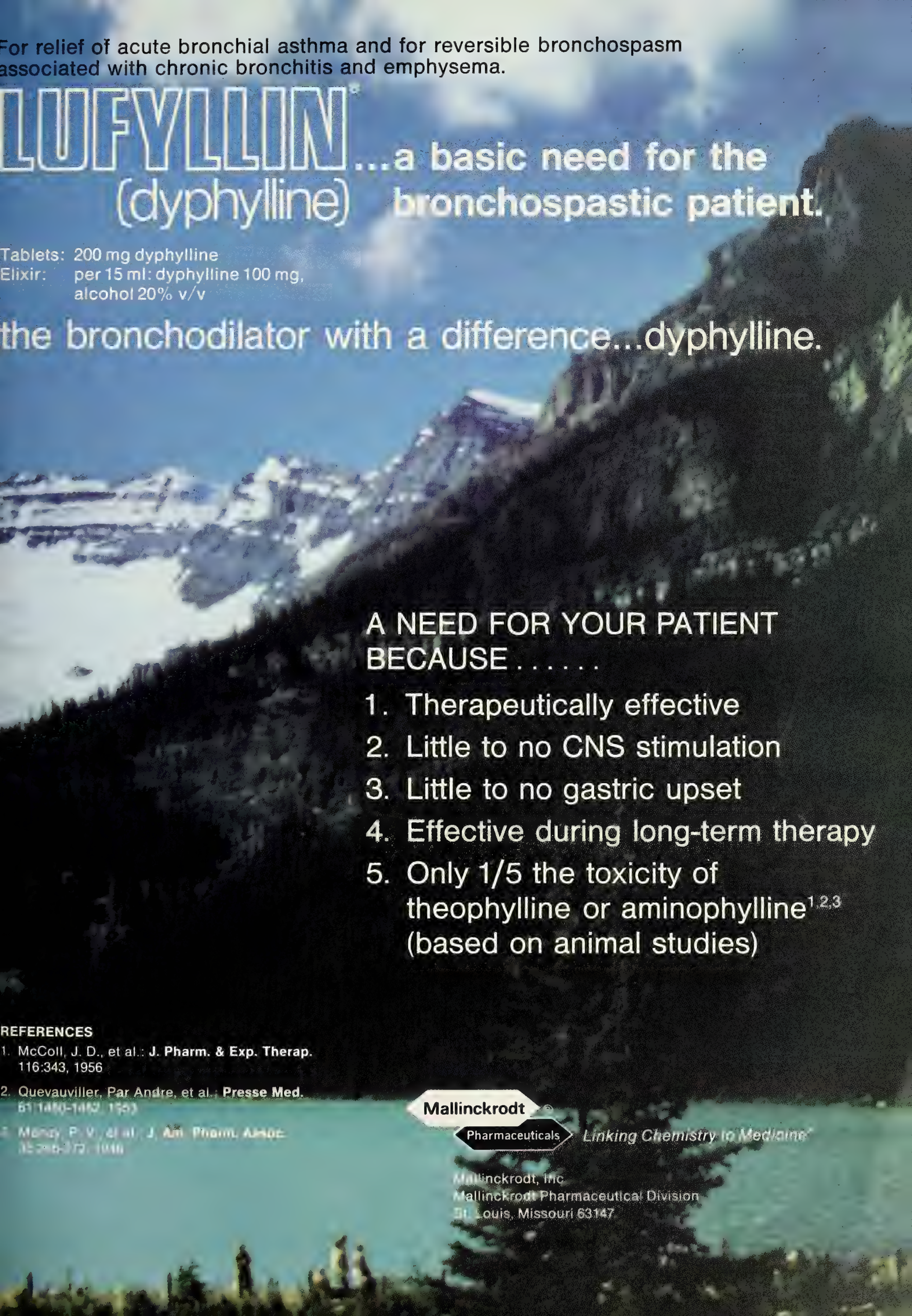

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welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Ramon Berguer, MD
1745 Anita
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Christine M. Bieniek, MD
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Asher Buxbaum, MD
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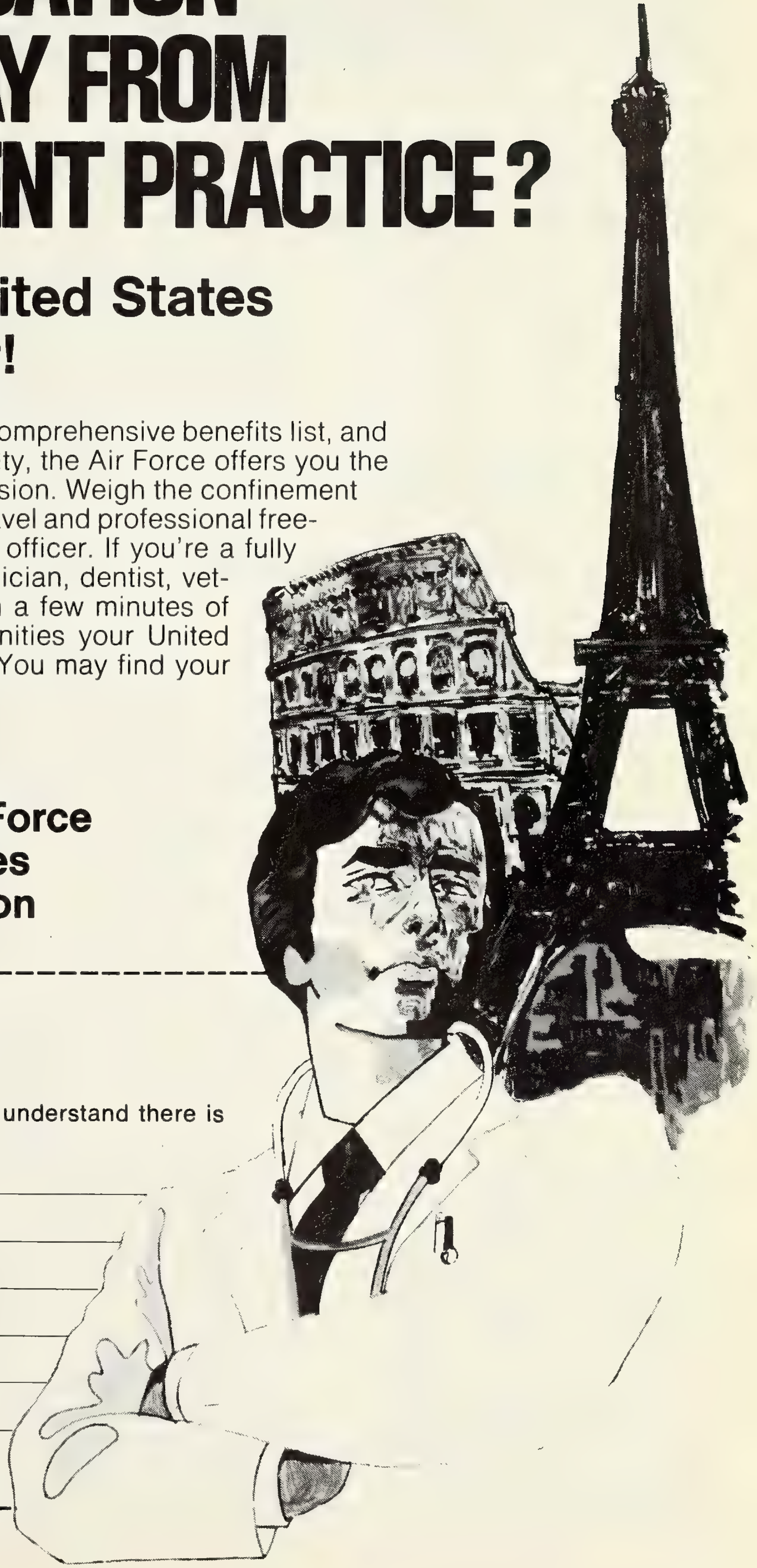

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Air Force Medicine

How to Figure What You Pay Under New Single Business Tax

By Edwin V. Ritzler
Battle Creek

On August 27, 1975, Governor William G. Milliken signed Michigan's single business tax into law. The tax is unique in that Michigan is the first state to impose a single tax on all business taxpayers operating within the state, regardless of their form of operation.

Like all new tax laws, the bill is a complex piece of legislation. Fortunately, most physicians can estimate their tax liability by applying the tax rate of 2.35% to one-half of their gross professional income for the year (or 1.175% of gross professional receipts).

The concept of the single business tax (formerly called the business privilege tax) is to levy a tax on the total business activity in the State of Michigan. To practitioners, this is gross cash receipts.

Proponents of the law have indicated several areas in which they feel this tax would be more equitable for the total business community than the income tax, and other taxes placed on corporations, partnerships and trusts. These people feel that the corporate income tax, which does not apply to the self-employed physician and small businessman is discriminatory to the businessman who incorporates. They contend that the present tax structure falls unevenly on segments of the business community which have a heavy concentration in capital investments, and argue that such industries as autos, steel, chemicals, etc., are the type that the state should encourage and favor because they produce more jobs. Act supporters also say that income taxes cause a lack of stability in revenue production since revenues rise in good times and then, of course, decline when business is slow. Also, they maintain that when tax revenues decline, demands for government services simultaneously increase. They conclude that the single business tax, tied to gross receipts, is a more stable tax base for the state. They believe it will overcome the cyclical effect and what has been referred to as the "spend tax syndrome."

The "spend tax syndrome" is a label for the belief that the government will spend whatever revenue it takes in. In times when profits are large and revenues are high, new programs are adopted and government becomes committed. When revenues fall off in recessionary periods, the programs that have been established are difficult to curtail. Hence, a budget crisis is created for the legislation.

The governor and legislature theorize that with their new tax, they now have solved a problem for everyone.

The single business tax will replace the existing corporate income tax, financial institutions tax, corporate franchise tax, savings and loan privilege tax, the business portion of the intangibles tax, and the personal property tax on inventories that is levied by local governments. The revenue raised by the new tax will about offset the dollars previously realized by the repealed taxes so that the net income to the state remains unchanged — at least after 1976.

Obviously, from the standpoint of the solo physician, or partnership of physicians, there are no taxes being repealed that will save money. Incorporated physicians, though, will save minor amounts of tax and much paperwork through the repeal of the corporal income tax, the corporate franchise tax and intangible taxes.

It has been our experience that the average corporation will pay approximately $250 in income and franchise taxes per physician in a corporation. We estimate that the average physician in Michigan will pay approximately $1,200 to $1,500 through the single business tax.

To estimate impact of the new business tax, the practitioner must first arrive at what is called the "tax base."

The tax base consists primarily of profits from the practice, compensation paid (including salaries, wages, social security, unemployment, and other payroll taxes, workmen's compensation, health insurance, pension and profit sharing contributions, and all other fringe benefits), net interest on business loans and depreciation. After arriving at the tax base, a flat rate of 2.35% is applied to arrive at the tax liability. The tax rate is the same for all business taxpayers, whether corporation, partnership or sole proprietorship.

There are the following exceptions:

Gross Receipts Limitations – The tax base may not exceed 50% of gross business receipts.

Labor Intensive Deduction – In lieu of the gross receipts limitations, businesses with high labor cost may deduct from their tax base a portion of compensation including all fringe benefits and taxes, which exceed 65% of the gross tax base.

Capital Acquisition Write-Off – The tax base is reduced by 100% of the cost of acquisitions of personal property real estate in Michigan acquired after January 1, 1976.

Small Business Exemption – Taxpayers with business income (gross cash receipts) of less than $34,000 will be allowed an exemption of $34,000 from their tax base. The exemption is phased out at a rate of losing $2 of exemption for ever $1 of gross receipts above $34,000, until you reach $51,000 of gross receipts, at which time this exemption no longer applies.

The single business tax, as with income taxes, requires "quarterly estimate payments". The first estimate payment will be due April 30, 1976. Estimate installments for the year must be at least 90% of the tax liability or the taxpayer will be subjected to a penalty.

Fiscal year corporations will be required to file a final Michigan corporation income tax return by April 15, 1976, for the portion of their fiscal year which begins in 1975 and ends December 31, 1975. Corporations will also be required to file by May 15, 1976, a final Michigan franchise tax for the year of 1975. Many of the regulations that will implement the single business tax, including regulations on how to file the final corporate income tax returns for fiscal year corporations, have not yet come from the Michigan Department of Revenue.

The Michigan single business tax becomes effective January 1, 1976. The repealed corporate taxes will be filed for the year 1975 and end thereafter.

In summary, the single business tax will add to the tax burden of physicians practicing in Michigan.

In addition to higher taxes, practitioners will in all probability be paying higher prices for supplies and services purchased from Michigan concerns, and will very possibly, in the first year, be faced with higher administrative costs as the new tax is phased in.

Mr. Ritzler is with Black and Skaggs Associates, Inc.

Monthly Surveillance report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the Four-Week Period Ending November 28, 1975

	1975 This 4-Week Period	1974 Same 4-Week Period	1975 Total To Above Date	1974 Total Same Date	Total Cases for 1974
Rubella	82	72	1,591	1,345	1,388
Cong. Rubella Syndrome	0	0	1	0	1
Measles	73	122	3,162	2,220	2,365
Whooping Cough	15	8	88	91	104
Diphtheria	0	0	1	0	0
Mumps	556	511	8,963	6,274	7,230
Scarlet Fever & Strep Sore Throat	1,804	1,764	20,931	29,731	31,802
Tetanus	0	1	0	4	6
Poliomyelitis (paralytic)	0	0	0	1	2
Hepatitis	218	259	2,612	3,396	3,599
Salmonellosis (other than S. typhi)	86	68	796	929	1,001
Typhoid Fever (S. typhi)	0	1	9	11	11
Shigellosis	33	119	683	1,323	1,436
Aseptic Meningitis	30	5	261	149	162
Encephalitis	21	11	141	66	69
Meningococcic Meningitis	4	4	72	48	54
H. Influenza Meningitis	12	9	120	111	121
Tuberculosis	93	81	1,105	1,021	1,431
Syphilis	127	183	1,514	2,499	2,659
Gonorrhea	2,610	2,715	29,741	29,734	32,152

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

in memoriam

Carl S. Cook, MD
Palmetto, Fla

Holland obstetrician-gynecologist for 30 years, Carl S. Cook, MD, died Nov. 10 at the age of 72. He had retired in 1971 and made his home since in Florida. Doctor Cook was a graduate of the University of Michigan Medical School. He practiced on Mackinac Island for eight years before opening his Holland practice in 1931. He also attained the rank of commander with the US Medical Corps during World War II.

Chester A. Doty, MD
Sun City, Ariz

Former Detroit dermatologist Chester Arthur Doty, MD, died Oct. 28 at the age of 93. Doctor Doty had been residing in Arizona since 1965. He was a graduate of the Detroit College of Medicine and Surgery and practiced in Detroit for 46 years. He was former head of the dermatology departments of Wayne County General and Highland Park General hospitals and had been affiliated with Womens and Harper hospitals. He was a member of the American Academy of Dermatology and Chicago Dermatological Society, and was past president of the Detroit Dermatological Society.

James S. Feurig, MD
East Lansing

James S. Feurig, MD, East Lansing, director of Michigan State University's Health Center and head physician for the MSU athletic program, died Nov. 17 at the age of 59. Doctor Feurig was a former Green Bay Packer lineman, and played professional football for three seasons to finance his medical education at Marquette University. Doctor Feurig practiced in Milwaukee, then on the staff at the University of Missouri, and joined MSU in 1953. Doctor Feurig had served as Spartan team physician since 1953 and directed MSU's Olin Health Center since 1961. He was professor of medicine at MSU. He received the Air Medal and Distinguished Flying Cross during World War II. He was a member of the American Academy of Family Physicians, Aero-Medical Association, and American College of Surgeons of Trauma.

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William L. Harrigan, MD
Midland

Longtime Mt. Pleasant obstetrician-gynecologist William LeRoy Harrigan, MD, died Nov. 9 at the age of 75. Doctor Harrigan was retired director of the Mt. Pleasant Center for Human Development and past president of the Isabella County Medical Society. He was a graduate of Marquette University Medical School and was affiliated with Midland Hospital.

Charles E. Hart, MD
St. Clair Shores

Detroit physician for 36 years, Charles E. Hart, MD, died Nov. 25 at the age of 63. Doctor Hart was affiliated with St. Joseph Mercy Hospital, Detroit, since licensure and was a graduate of Wayne State University. He was a member of the National Surgeons of the China-Burma-India Veterans Association.

Arthur B. Henderson, MD
Grosse Pointe Park

Arthur B. Henderson, MD, Detroit family physician for 55 years, died Nov. 24 at the age of 92. Doctor Henderson was a graduate of the Detroit College of Medicine and Surgery and was affiliated with East Side General and Deaconess hospitals.

Lawrence A. LaPorte, MD
Saginaw

Saginaw family physician, Lawrence A. LaPorte, MD, died Oct. 21 at the age of 67. Doctor LaPorte was former director of the Michigan Division, American Cancer Society, and had been affiliated with St. Joseph Hospital of Tawas City. He was a graduate of Loyola University medical school.

Thomas A. McLennan, MD
Flint

Former Kalamazoo-area family physician and surgeon, Thomas Alex McLennan, MD, died Nov. 18 at the age of 50. Doctor McLennan had been affiliated with Bronson Methodist, Borgess and Kalamazoo hospitals in Kalamazoo and Crispe Hospital of Plainwell. He was a fellow of the Royal College of Surgeons of Canada and a member of the Royal Society of Medicine of England.

Samuel C. Petix, MD
Bloomfield Hills

Bloomfield Hills surgeon Samuel C. Petix, MD, died Nov. 18 at the age of 67. Doctor Petix had retired in 1972. He was affiliated with Mt. Carmel Mercy and Providence hospitals, Detroit. He was a graduate of Wayne State University School of Medicine and a member of the American College of Surgeons.

J. Mott Rawlings, MD
Grand Blanc

Grand Blanc family physician, J. Mott Rawlings, MD, died Nov. 19 at the age of 75. Doctor Rawlings was affiliated with Saginaw County, Hurley, St. Joseph and McLaren General hospitals in Flint. He was a graduate of Johns Hopkins Medical School.

Lorenz J. Schermerhorn, MD
Menlo Park, Calif.

Former chief of pediatrics at Butterworth Hospital, Grand Rapids, Lorenz J. Schermerhorn, MD, died Nov. 19 at the age of 86. He had been residing in Menlo Park, Calif., since retirement in 1957. Doctor Schermerhorn was Butterworth pediatrics chief from 1933 to 1953 and also chief of staff at that hospital. He was a graduate of the University of Michigan Medical School and was certified by the American Board of Pediatrics.

Suel A. Sheldon, MD
Saginaw

Suel A. Sheldon, MD, Saginaw family physician for 44 years before his retirement in 1968, died Nov. 12 at the age of 78. Doctor Sheldon was affiliated with Saginaw General, St. Mary's and St. Luke's hospitals of Saginaw. He was past president of the Saginaw County Medical Society and past president of the Saginaw General Hospital senior staff. He was a gradute of the University of Michigan Medical School.

Benjamin Schlain, MD
Birmingham

Birmingham pediatrician Benjamin Schlain, MD, died Sept. 9 at the age of 75. Doctor Schlain was a graduate of the University of Michigan and was a member of the Detroit Pediatric Society.

Reader J. Hubbell, MD
Laguna Hills, Calif.

Doctor Hubbell

MSMS Past President Reader J. Hubbell, MD, formerly of Kalamazoo and Traverse City, died Nov. 22 at the age of 79. Doctor Hubbell led the state medical society in 1952-53. A urologist, Doctor Hubbell was affiliated with Bronson Methodist and Borgess hospitals in Kalamazoo, where he also served as president of the Kalamazoo Academy of Medicine. Doctor Hubbell moved to Traverse City in 1960 and practiced there until his retirement and move to California in 1970. He was a graduate of Northwestern University Medical School, a fellow of the American College of Surgeons, member of the American Board of Urology and the American Urological Association.

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POTPOURRI

By Herbert Auer, Executive Editor

MSMS is one of the active participating groups in a new program by the State Civil Service Commission to recruit physicians for state positions. The MSMS Department of Communications has indicated a series of possible services to help the state inform interns, residents, and physicians about job opportunities in Mental Health, Public Health, Corrections, etc. Jennie Washington, head of recruitment for the Civil Service Commission, has thanked MSMS for its advice, counsel and assistance.

* * *

There's an interesting suit in Grand Rapids that could have national implications. The U.S. Justice Department has filed a suit against the American Pharmaceutical Association and Michigan State Pharmaceutical Association charging the APA ban on prescription drug advertising is illegal and a violation of the antitrust Section I of the Sherman Act. The Justice Department reports that comparable action against association bans in the medical and law professions are also being considered.

* * *

One of the bumper stickers appearing across the nation says, "If you like the postal service, you'll love National Health Insurance."

* * *

In a recent national study people in the midwest reported they were "very satisfied with their health" more often than people in any other area of the USA. 76% gave that comment, which was several points above the national average. The study, asking many questions about attitudes, work, families, etc., was conducted by the University of Michigan Institute of Social Research and soon will be published as "The Quality of American Life."

It's refreshing to hear Theodore Cooper, MD, HEW assistant secretary for health, declared that, "I do not favor increasing direct federal intervention in the field of medicine." He has said many times, "The reliance on federal control of the health care system will lead to a rigidity and dehumanization of the practice of medicine that would make the right to health care — even if that goal were finally achieved — a hollow and bitter prize for everyone." Doctor Cooper declares further, "The federal government cannot effectively manage the health care system of this country. I hope that job is never given to us."

* * *

Do more of your patients seem older? It is true that the number of people over 65 increased by more than 20% during the past decade or 7% more than the general population growth. Today, 1 of 5 Americans is over 55 and 1 of 10 is over 65.

* * *

A bill has been introduced in the Michigan House of Representatives that would give county commissioners the power to appoint all board members to the local HSAs, mandated by federal law. The bill would require that one-third of the HSA board members should be members of the county commission. The bill, HB 5785, was introduced by Reps. Hood and Kehres.

* * *

Do you always buckle up when you drive your auto? Injured motorists who aren't wearing seat belts may be at a disadvantage if they sue for personal injuries. A motorist recently lost a suit in the New York State Court of Appeals because he did not have his belt buckled.

Physicians interested in objective viewpoints about chiropractic will want to read the two-part series about chiropractors in the September and October issues of Consumer Reports, available at most public libraries.

* * *

The debate of substitution of generic drugs has been going on for some time and likely will continue as an issue of interest to legislators, consumerists, and health professionals. A Wayne State University study, reported at a recent meeting of the American Public Health Association in Chicago, found that more than one third of the pharmacists polled in a survey, matched up drugs that cannot be safely substituted. Of the 533 pharmacists who participated in the survey, an average of 43% were not able to correctly identify generic equivalents.

* * *

Would this message apply to physicians too? Ann Landers told the Overseas Press Club in NYC that newspaper editors should "Be kind; you never know how much a little friendship can mean to a person fighting depression and just trying to get through the day." Ann has the largest reading audience in the universe.

* * *

"The life of any medical society is dependent on the program committee. If the committee always puts over good meetings and always secures good speakers then the society is a successful one. In our society we aim to have not only speakers in our own science, but also speakers who can broaden our knowledge in other activities."

That advice was given 50 years ago by Fred S. Baird, MD, MSMS Council member, in MSMS Journal.

MICHIGAN MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 2 FEBRUARY 1976

WHAT COMMUNITY HOSPITALS NEED TO KNOW about CME programs — MSMS CME Commission lays it out in detail . . . page 66 inside

CATEGORY I-APPROVED CME PROGRAMS listed . . . page 77 inside

ARE YOU A U-M ALUM? You'll want to know about the many changes under-way at venerable U-M Hospital . . . page 80 inside

IF YOU'RE THINKING OF PRACTICING without any liability insurance at all, consider these ramifications . . . page 98 inside

ALSO, MSMS legislative plans for 1976, how to be a better lobbyist, practice management, MSMS insurance plans

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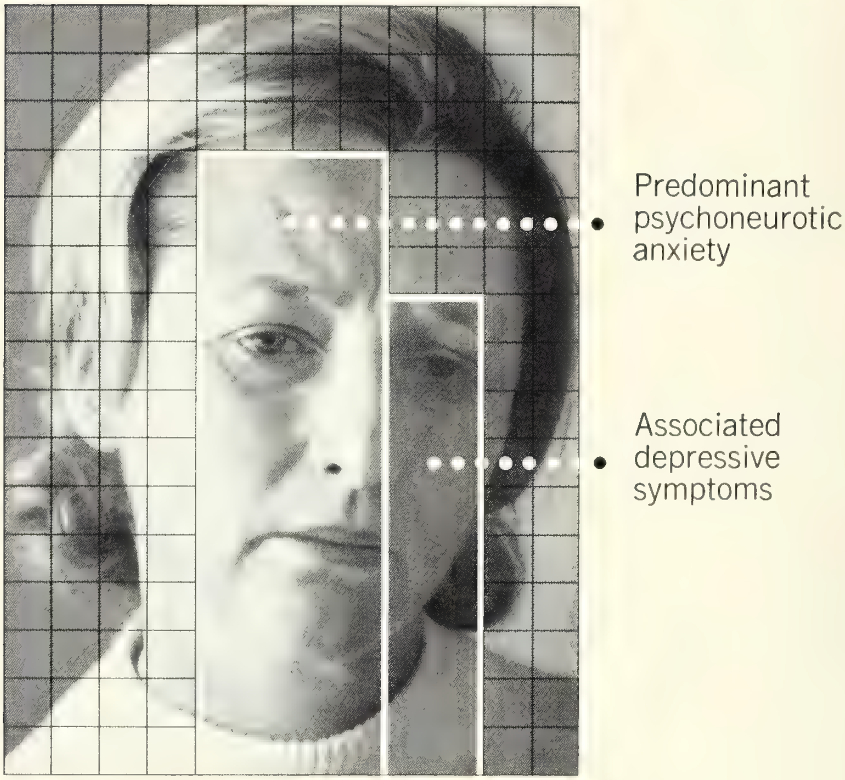
Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

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with associated
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surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors nd other antidepressants may potentiate ts action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the Next Issue

In the March issue, plans are for Michigan Medicine to publish articles on the new committees of the Michigan Physicians Mutual Liability Company; progress of the Michigan project to improve health care in jails; reorganization of the Michigan Hospital Association; advantages of a professional corporation, arbitration in the hospital setting, and the MSU Upper Peninsula medical school.

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Here's a vote against Health Manpower Bill

Brock E. Brush, MD
MSMS President

As an American and a physician, I personally oppose the federal legislation now in the U.S. Senate that would permit the federal government to dictate the personal careers of Americans.

The Health Manpower Bill HR 5546 has been passed by the House of Representatives. Most doctors and many Americans, I believe, are opposed to the parts of the Bill that:

(1) Would allow the federal government to regulate the number and location of medical residencies, and

(2) Would require medical students to repay the government for federal aid to medical schools.

IF HR 5546 SHOULD BECOME LAW, two new federal agencies would be established.

One would be responsible for accrediting medical residency training programs, and the other for establishing the number of positions which could be filled in each residency program. So rigid is the proposal that it even provides for penalties against physicians who enter nonaccredited residency training programs, or enter residencies where the number of first-year positions exceeds that established for that program. Physicians who failed to accept the government's dictates would then be subject to economic reprisals: they would not be paid for treating Medicare or Medicaid patients while serving their residencies.

THIS HOUSE BILL WOULD RATION the number and location of postgraduate training programs. Such a proposal would reduce the quality and quantity of patient care in many Michigan hospitals. The patients would be the losers.

The proposal provides federal financial aid for medical schools but with a big hooker. The proposal says the government will help medical schools finance education of medical students on a per capita basis *if* the schools require each student to enter into a "legally enforceable agreement" in which the student is bound to repay the United States government an amount equal to the amount that the government gave the medical school for his education.

As far as I know no other college student has to pay the federal government back for aid given the college.

THE MEDICAL PROFESSION HAS VOICED SUPPORT for some parts of the bill. The good parts deserve support. For example, there are provisions for continued federal assistance for medical education, including assistance to both schools and students. The Bill would provide assistance for training of other professionals and continuation of construction loans and grants for medical students, capitation grants to medical schools, assistance through a broad special project grant authority, loans and scholarships to medical students, the National Health Service Corps Program, training of students for family practice, assistance for public health training, and assistance for students and schools of nursing.

The AMA is leading the efforts to remove the undesirable elements. The AMA urges senators to support some amendments, or vote against HR 5546.

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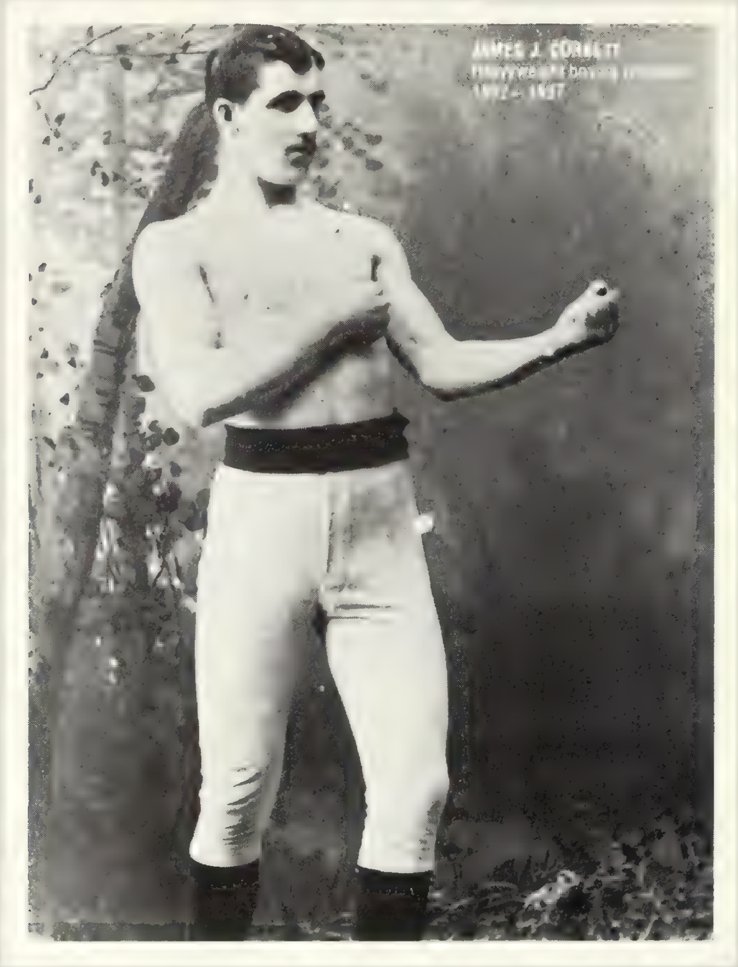

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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The new MSMS member benefits by not having to present evidence of insurability to enroll in the L-5 plan for $500 monthly benefit if enrollment is requested within 60 days of joining the MSMS. Other MSMS members may be required to present evidence of insurability satisfactory to the insurance carrier.

Features of the plan include total disability and partial disability benefits. Up to seven days' indemnity is payable for non-disabling injuries. Premiums may be waived which fall due after 90 days of total disability for the duration of this disability. The plan provides various benefits payable for accidental death or dismemberment. Benefits are payable for disability commencing after the effective date of insurance regardless of when the condition had its inception.

Protection under the plan remains in force as long as premiums are paid, membership is maintained in the MSMS, and the member actively practices in the State of Michigan. The policy is renewable to age 75.

The plan provides a special conversion feature whereby an insured physician may convert the policy to an individual policy guaranteed renewable to age 70. This conversion is available if the MD moves from the state of Michigan and continues active practice or if s/he ceases being a member of the MSMS. The conversion privilege is available to age 65.

House confinement is never required to collect sickness or accident disability benefits and claims are not pro-rated because of benefits received from other insurance.

Further details may be obtained from the administrators, Stratton-Cheeseman & Associates, Inc., P.O. Box 1563, East Lansing, Michigan 48823 — or call (collect) 517/351-5780. The underwriting company is Provident Life & Accident Insurance Company.

OOPS – We goofed! The MSMS group life dividend for 1974-75 was 35% of the annual premiums paid not 3%, as reported on this page of the January issue of **Michigan Medicine.** ***Doesn't this outstanding return warrant taking a look at this valuable group life insurance program – another MSMS membership benefit?***

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"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
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breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
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Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

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Establishing a CME program in the community hospital

By Roland G. Hiss, MD

Member, MSMS Commission on Continuing Medical Education

Rules and regulations governing the new Michigan law requiring 50 hours of continuing medical education (CME) per year for each Michigan physician have been described in a recent communication sent by the Medical Practice Board to each licensed doctor of medicine.

The law formalizes, in part at least, a philosophy long held by the medical profession, namely that the educational preparedness for the practice of medicine is not a static thing, but must be updated continually throughout the professional career of each physician. Acceptance of that philosophy is neither controversial nor difficult; but application of it to each physician regardless of his or her practice circumstance will require considerable innovation in medical education activities.

Some continuing education can and should be received by physicians attending formal postgraduate courses offered by medical schools, national societies, and similar organizations. But improvement of programs associated with the physician's own practice will be necessary to achieve the desired goal of improved patient care through continuing education.

Larger community hospitals which conduct graduate training programs have a wide variety of educational opportunities that result directly or indirectly from the curricular requirements of various residency programs. Medical education in these hospitals is (1) organized; (2) well staffed, and (3) reasonably well funded. Individual physicians affiliated with those hospitals need only be encouraged to participate in the activities already at hand.

For hospitals whose size and circumstance do not permit the conduct of graduate programs, the situation is more difficult. In many smaller community hospitals, CME has not been a regular procedure, and there has been no driving force to make it so. While the new Michigan CME law was one of many designed to ease the malpractice problem, it may also provide the necessary impetus to establish an organized approach to continuing medical education in practice settings which have not previously taken this step. In this sense, the stimulus to continuing medical education is a positive by-product of Michigan's serious malpractice situation.

For the past year and a half the Michigan State Medical Society Commission on Continuing Education has been actively tooling up to accredit local hospitals as providers of continuing medical education for their staff physicians. This article describes the observations and experiences of the Commission concerning CME in community hospitals, and will provide guidelines that may be useful to hospitals attempting to establish a regular system of CME as part of their daily professional activity.

The Nature of CME

The word "education" for many physicians means formal didactic pursuit involving lectures, facts, books, tests, grades, and some kind of diploma. These things are established parts of "education," but are only some of the more visible parts.

The modern concept of education incorporates the actual behavior of an individual, rather than the mere cataloging of facts. What an individual *does* is the important focus, and education is considered the process of change, modification, and improvement in that *doing*.

Information not put to use in daily activity (whether in medicine or any other profession) borders on being irrelevant, and is certainly at risk to being lost from recall. Its sole value often becomes what is termed "intellectual enrichment."

In the case of medical education, all physicians have been faced with, and have struggled through, sizable volumes of medical fact, much of which has been lost to disuse atrophy. If continuing medical education is a repeat of this painful and cumbersome process, there would be little to say for it. If, however, continuing medical education is defined in terms of *actual change* of physician performance in the care of his or her patients, then a strong case for CME easily can be made.

Fundamental to any effort to establish CME in community hospitals must be a basic concept that its purpose is improvement of patient care brought about by changed (presumably in the direction of improvement) physician performance. The educational activities described below have this singular purpose.

Category I Approved Programs

The rules and regulations pertaining to required continuing medical education for relicensure of Michigan physicians define five categories of educational activities in which credit towards the 50 hour requirement may be obtained.

Of the five, Category I presents both the greatest challenge and the greatest influence for change in CME at local hospitals. Category I credit is received by participation in programs sponsored by agencies approved by the AMA Council on Medical Education (organizations operating at the national level), or from the MSMS Commission on Continuing Medical Education (organizations operating locally). Any Michigan hospital, clinic, state professional society, or other cohort of physicians can potentially receive approval for this purpose from the MSMS Commission.

The new state law provides power for the State Medical Practice Board to also approve Category I experiences, but the Board has no special procedures or desires at this time to function as an accrediting body.

Approval will be based on an organization's capability (judged by defined standards*) of conducting programs which meet Category I criteria. These criteria are not new, nor applicable only to the state of Michigan. They have been several years in development and are used nationally by the AMA, and locally by approximately 40 state medical societies. They are derivations of criteria originally established by the AMA for its Physician Recognition Award (PRA) and, with some modification, have stood the test of time and have received general acceptance.

The criteria are realistic — that is, they are "do-able"with modest effort by any hospital or medical organization. While several criteria are involved, the four fundamental ones are as follows:

1. An accredited program must be designed as a continuing medical education program. The CME programs must deal with direct patient care matters, not business affairs, administration, or facilities. Programs for house officers, medical students, and other health personnel are not applicable.

2. The programs must be under the direction of an identifiable administrative focus within the approved organization. There should be some person, office, committee, or other suitable agency with defined responsibility for continuing medical education within that practice cluster.

3. The programs must have defined educational objectives, and these objectives should be based on determined educational need. (The results of audit studies are the most direct way to accomplish this, but a planned curriculum responsive to the perceived needs of the participating group is also acceptable.)

4. The programs must be evaluated. Evaluation of educational impact is difficult, but evaluation of the conduct of the program with feedback to the planning agency can and must be accomplished.

These four criteria can be met by virtually any organization. The administrative focus for CME can be an education committee (many hospitals have these now), an enthusiastic physician willing to spend a couple of hours per week, a hospital administrator, or other member of the hospital staff.

The main point is, however, that responsibility for CME be defined and that the person or agency so designated supervise the components of the CME program — needs assessment, curricular design, program planning, program execution, evaluation, and record of credits.

Evaluation of Programs

Educational design based on determined educational need is not a simple art. Exact determination of educational need requires precise preset performance criteria, exact measurement of individual performance against these criteria, and determination of the gap between criterion performance and measured performance. This ideal is almost impossible to achieve in any hospital, large or small, but a near approximation of it *is* practical.

Medical audit is required by the Joint Commission on Hospital Accreditation, and other regulatory bodies, and has recently become established as a routine in American hospitals. The results of audit activities are available and can be channeled into educational planning, and should be. In addition, there are many areas of medical practice which deal with difficult old medical problems, or brand new ones, which can be judged appropriate subject matter for educational programs without precise needs assessment to prove it.

A curriculum for several months to a year can be designed using, as an example, the most common discharge diagnoses of a given hospital (determined from PAS data). Prestated educational objectives — that is, a statement of the desired change on the part of the audience — can be distributed to the recipient audience and a definite program planned.

**These will be supplied to applicant hospitals by the MSMS Commission.*

The requirement for objectives and planning is fundamental and, conversely, the sporadic one-hour program staged largely because of popularity or availability of a speaker *does not* meet criteria.

Sage words dealing with the subject of evaluation have been tumbling through the medical education literature for the past 10 years. Despite high sounding claims, evaluation of change of physician behavior resulting from educational activities is an impossibility except in certain specific research settings. Evaluation of the effectiveness of educational programs in terms of changed physician behavior is therefore not realistic; but evaluation of the educational presentation is. The audience can be asked to respond to the quality of the program with reference to teaching effectiveness, practical value, improvement of understanding of the subject matter, and the level of the subject matter.

A sample evaluation instrument representing one way in which this can be accomplished is displayed in **Figure 1.** Each attending physician is asked to circle the number in each of the four columns representing his or her judgment within that category. These are then collected and collated by the agency responsible for CME in that hospital for feedback to the instructor and for use in planning subsequent programs. (If audit results *were* the basis for the planning of a program, a follow-up audit on the same subject would provide evidence of successful change in physician performance resulting from the educational activity.)

The use of the Medical Education Number (an 11-digit number assigned to every American physician by the AMA) permits the CME staff to maintain a record of physician attendance. (Desire for recorded credit is a stimulus to each physician to complete the evaluation card.) The right upper corner of the suggested form is used to write in the date, topic, and instructor of an individual session. This simplified method of evaluation is offered as one suggestion as to the way in which evaluation can be accomplished. This exact method is not specifically required.

Establishing and Conducting Category I Programs

Fundamental to all programs is the principle that their design attempt to achieve a change in behavior on the part of the recipient audience. In order to do this, the person conducting an individual program must make a judgment about the level of performance of the attending audience with reference to some medical topic, and then formulate a clear idea about how this performance is to be changed as a consequence of the educational program.

Members of the MSMS Commission on Continuing Medical Education, and the institutions they represent include:

Louis E. Heideman, MD, MSMS Council, chairman
Richard W. Pomeroy, MD, E. W. Sparrow Hospital, Lansing, vice chairman
Philip Adler, DO, Michigan Association of Osteopathic Physicians and Surgeons
Robert M. Daugherty, MD, PhD, MSU College of Human Medicine
Laurence Bruggers, MD, Michigan Society of Obstetricians and Gynecologists
Edmond J. Gostine, MD, Michigan Academy of Family Physicians
Roland G. Hiss, MD, University of Michigan
Conrad R. Lam, MD, Henry Ford Hospital
John W. Moses, MD, Michigan Medical Practice Board
Robert M. Nicholson, MD, Michigan Hospital Association
William E. Rush, MD, Wayne State University
Joseph A. Sentkeresky, MD, Michigan Society of Internal Medicine
David Siegel, MD, private practice
E. Thurston Thieme, MD, Michigan Chapter, American College of Surgeons
Robert L. Tupper, MD, Michigan Association for Medical Education

Simply stated, the instructor must decide "what we do now" and "what we should be doing." For instance, educational targets might be the proper use of a new laboratory test or drug, discontinuation of an outmoded or dangerous procedure, installation of a new surveillance procedure, change in referral pattern, or changed procedure for use of blood products.

Any educational program should include a review of the basic concepts involved to assure a sound "understanding" of the subject, but there must be some defined activity which the participating physician should acquire in his or her practice as the end point.

Hospitals with already established regular educational programs have a relatively small job to bring every program up to Category I standards. Some improvement in curricular planning, particularly emphasizing the need to incorporate audit results in the educational process, and development of an evaluation scheme are all that is required.

Ongoing programs such as departmental grand rounds, CPCs, subspecialty conferences, and journal clubs are all potential Category I programs if they are brought under the administrative umbrella of a defined CME organization within the hospital.

For the smaller hospital whose educational programs are sporadic and widely spaced, a bigger effort will be required. The first step is the establishment of some CME structure — physician, administrator, committee, or whatever — with the mandate and enough office and educational equipment to do the job. The CME unit must then think through how it will meet the four required criteria for Category I programs, establish the necessary internal machinery, and seek regular feedback from the medical staff as to the planning and conduct of the programs.

Weekly Staff Conferences A Good Bet

A time-honored cornerstone to the ongoing educational activities in many hospitals is the weekly staff conference. Whether the "staff" are the physicians associated with one departmental discipline (medicine, pediatrics, obstetrics), or whether it represents broader categories of physicians will depend on the hospital size and its tradition. Size alone of the medical staff is not a critical factor. A handful of physicians can sustain an active and valuable educational program if they are organized and committed to the program's success.

Following is a list of potential formats for the weekly staff conference which have been found to be useful at various hospitals:

1. *Discussion of audit activities*: An audit committee will presumably have the operative responsibility for working through audits. However, a review for the general staff of the criteria which they have selected will provide valuable input to the committee and be a strong educational influence on the staff. When the audit is complete, a review of its results almost always stimulates interest and heated discussion, the results of both being positive. A staff meeting devoted to audit discussion three or four times per year is recommended.

2. *"Local expert" presentation*: Most physicians have a topic or disease entity which is of particular interest to them and with which they have more experience or training than their peers. In order to share this "expertise," and to spread the work of preparing staff conferences around, each physician on the staff can be assigned (or asked to volunteer) for one staff conference per year on a topic which fits the yearly curriculum. This "instructor of the week" can research his or her topic, make the necessary judgments concerning educational objectives, seek consultation from any resource available, plan a presentation, and "enjoy" one hour in the limelight. Although some of the early presentations in such a program may not be spectacular, they will improve with experience (and the evaluation scheme will feed back pertinent commentary). The educational value to the "teacher" of preparing such a session is appreciable. The presentation of a typical patient representing the problem at hand serves to generate interest and keep the program on a clinical course. The use of simple handouts supplying factual information for future reference will markedly improve the lasting value of the program.

3. *"Visiting expert" presentation:* There are some topics for which the physician resources are not locally available to stage the required program. An invitation to a visiting discussant can help with this problem. It is important to point out that the visitor need not be from a distant university, but can be the consultant to whom problems of the type under consideration would ordinarily be referred. Travel distance and expense, as well as availability of the needed resource, are facilitated by this practice.

4. *Self-instruction programs*: Some hospitals have set aside certain staff meetings for the discussion of self-instructional programs available to the medical staff for individual study prior to the general session. These are particularly useful in small hospitals with relatively small numbers of physicians.(Editor's note: The March issue of *Michigan Medicine* will describe the Media Library program of the University of Michigan.)

5. *Clinical pathological conference*: The CPC has earned a good reputation through decades of undergraduate and postgraduate medical education as a means of correlating the attending physician's clinical observations with the pathologist's findings. Three or four CPCs per year jointly conducted by a clinician and a pathologist could be useful additions to the overall education program.

6. *X-ray conference*: The radiology department can be asked to present three or four conferences per year in which radiographic examination of some organ system or disease entity is reviewed in depth, with the use of demonstration X-rays. (Similar conferences concerning other procedures such as electrocardiography might also be considered.)

7. *Meeting reports*: Many physicians regularly attend national postgraduate programs and gain new information, new insights and new skills. They might volunteer to share these experiences with their peers through the modality of a presentation at a staff conference.

The weekly staff conference has the potential for providing 50 hours per year of Category I medical education to each of the attending physicians associated with a hospital with an approved program. Although emergencies, vacations, and other day-to-day interruptions will prevent any one physician from obtaining all 50 of his or her total credits from hospital staff conferences, it is not unreasonable to predict that the 25 hours of required Category I credit can be obtained locally in this fashion.

The individual physician can then supplement this basic educational program with attendance at postgraduate courses elsewhere, or from activities in the other four categories of CME. Whatever the case, a weekly educational program will provide a mechanism for improving patient care and a forum in which physicians who work together can regularly seek and receive a professional interchange with their peers.

Financing of Hospital CME Programs

The activities described above will inevitably generate certain costs. The federal government and most local governments have long voiced the philosophy that the continuing education of a self-employed professional (such as a physician) should be financed by that individual. It is unlikely that this philosophy will change in the near future. For this reason, a significant portion of the direct costs for these programs must be provided by the active medical staff, probably through a dues mechanism.

The hospital itself can and should play a definite role, however. The quality of care rendered within a hospital is the corporate responsibility of that hospital, and this responsibility requires an active part in the financing of all hospital-based educational programs. Common pattern is to have hospital administration provide the financial support for the educational facilities (classrooms, audiovisual equipment), the medical library, the medical records department, the costs of audit, and some basic administrative support such as publicity, secretarial help, a credit

Name of Hospital:

Medical Education Number: ☐

Topic:

Instructor:

Date:

Instructions: Circle the number in each column which expresses your reaction to the presentation.

Quality of Instruction	**Value of Subject Matter To Me**	**Improvement in Understanding Subject Matter**	**Level of Subject Matter**
1. Poor	1. None	1. None	1. Very elementary
2. Somewhat inadequate	2. Little	2. Little	2. Somewhat elementary
3. Adequate	3. Moderate	3. Moderate	3. Satisfactory
4. Very good	4. Considerable	4. Considerable	4. Occas. incomprehensible
5. Exceptional	5. Exceptional	5. Exceptional	5. Incomprehensible

Figure 1. Suggested format for evaluation card.

accounting system, and the like. Direct costs of the program including honoraria and travel expense of visiting speakers, purchase of educational packages, and media preparation should be subsidized by the receiving audience. There is no set prescription as to how these costs should be shared between the hospital and the medical staff, but they should be shared rather than being the sole responsibility of one party or the other.

The Accreditation Mechanism

The Michigan State Medical Society Commission on Continuing Education has been delegated the authority by the AMA to review applicant hospitals and organizations and to approve them as CME providers if they fulfill basic requirements. Inquiries concerning the technicalities of this procedure should be directed to MSMS headquarters. Only an outline of the process can be presented here.

The applicant hospital will be asked to submit to the MSMS Commission a pre-survey questionnaire which contains background information, organizational arrangements, and other matters pertaining to the educational program for which approval is requested. Upon review of this questionnaire by the Commission, the hospital will be reviewed either by a site visit team or with a so-called "site visit in reverse." In the latter case, hospital representatives will be asked to meet with the Commission (usually at the MSMS headquarters building) and respond to questions pertaining to their educational program. In either instance, it is the Commission's intention to ascertain that the applicant hospital is prepared to conduct Category I programs.

Approval will be given by the MSMS Commission to the applying institution, and not for any individual program it might conduct. The applying institution in its application will declare which of its activities are of the Category I type. Approval is for one to four years on a conditional or unconditional basis, and there usually is the request that an annual report be submitted to the Commission for review.

Whereas individual hospitals may choose to apply for accreditation on their own, they may also choose to join other hospitals in a collaborative effort and apply as a consortium. Decision to do this would be based on local factors. If the latter route is chosen, it will be important to establish a single CME organization for the consortium and show evidence that it is a unified, not fragmented, body.

Summary

The new Michigan law mandating 50 hours of continuing medical education (CME) as part of the relicensure process for each Michigan physician is a healthy stimulus for the establishment of ongoing educational programs in all hospitals, clinics, and professional organizations.

The development of a regular educational program in parallel with the patient care activities of any group of physicians has clear potential for significant improvements in patient care.

Larger hospitals with established graduate and continuing education programs should have little difficulty in amending these programs so that they fulfill the four basic criteria of a Category I approved CME activity.

Smaller hospitals which have not heretofore established a regular educational program will require a greater initial effort, but the creation of a sound program in any hospital is entirely possible and should be accomplished. Several suggestions concerning organizational arrangement and program format are described.

consider the effect on coexisting glaucoma when you prescribe a vasodilator*

a vasodilator that has not been reported to raise intraocular pressure

VASODILAN®

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TABLETS, 20 mg.

the compatible vasodilator

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*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Fifteenth Annual

MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL HEALTH

March 24-25, 1976

Kalamazoo Center Inn, Kalamazoo

NO REGISTRATION FEE

All physicians, nurses, and students are invited by the Michigan State Medical Society Committee on Maternal and Perinatal Health to participate in this excellent postgraduate program. Application for continuing medical education credit for physicians has been made.

— John M. DeVries, MD, Kalamazoo
Chairman, Conference Program Committee

Wednesday Afternoon, March 24

FIRST SESSION: Antepartum Problems

"An Update on Genetic Risks & Counseling,"
James Neel, MD, Ann Arbor
"Ultrasound in Antenatal Assessment,"
John Karo, MD, Detroit
"Fetoscopy – a Look Into the Fetal Environment,"
Ronald Benzie, MB, CHB, Toronto

SECOND SESSION: Intrapartum Problems

"Biochemical Induction of Fetal Lung Maturation,"
Richard Zachman, MD, PhD, Madison, Wisconsin
"Determination of Fetal Distress,"
Marilyn Lapidus, RN
Question-and-Answer Session — Panel

Evening Banquet

Music: Western Michigan University Vagabonds
Speaker: Charles A. Smith, noted humorist

Thursday Morning, March 25

THIRD SESSION: The Problem Infant

"Amniotic Fluid as a Genetic Indicator,"
B.B.K. Pirani, MB, CHB, Toronto
"Unexpected Abnormalities in the Newborn,"
D. F. Johnson, MD
"The Family's Response,"
D. W. Hoffman, ThM, Grand Rapids

FOURTH SESSION: Diabetes & Pregnancy: 1976

"Diabetic Screening in Pregnancy,"
Charles Tenner, DO, Detroit
"The Mutual Interaction of Diabetes & Pregnancy,"
Sumer Pek, MD, Ann Arbor
"The Infant of the Diabetic Mother,"
Richard Zachman, MD, PhD, Madison

Related Meetings

Wednesday Morning, March 24

Special Program for nurses arranged by the Michigan Section, Nurses Association, ACOG, District V

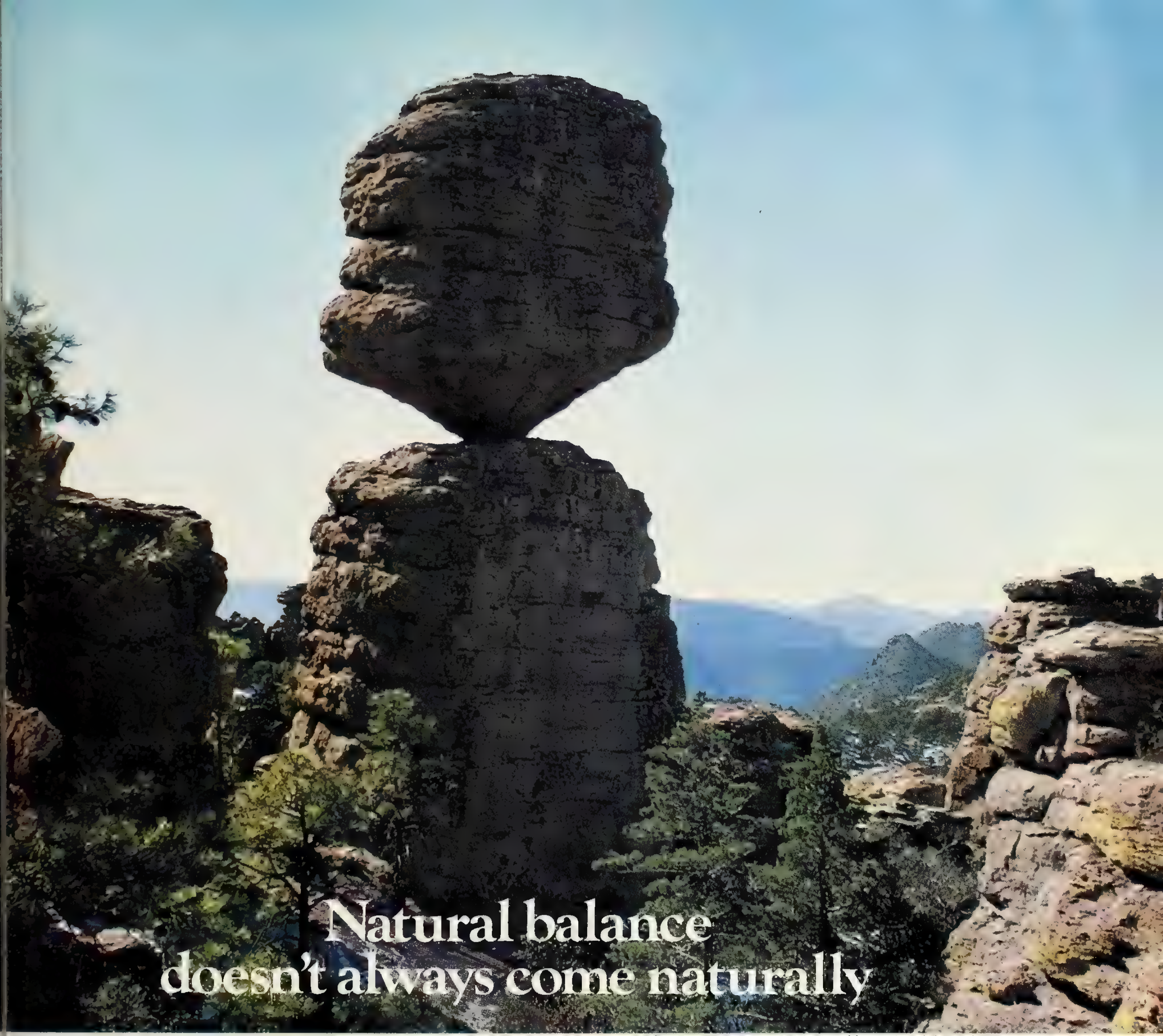
Speakers: Patricia L. Gober, RN, Grand Rapids,
Gene Cranston Anderson, RN, Chicago;
Sheila Ward, RN, MPH, Lansing

Thursday Afternoon, March 25

The Perinatal Association of Michigan will hold an education meeting

For Program and Details, write:

Herbert A. Auer,
Michigan State Medical Society,
P.O. Box 950
East Lansing, MI 48823



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

nd useful in the management of vertigo* associated with es affecting the vestibular system.

n relieve nausea and vomiting often associated with vertigo.*

ual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

o available as Antivert (meclizine HCl) 12.5 mg. scored s, for dosage convenience and flexibility.

tivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for a, vomiting and dizziness associated with motion sickness.

UMMARY OF PRESCRIBING INFORMATION

ICATIONS. Based on a review of this drug by the National Academy of ces—National Research Council and/or other information, FDA has classified dications as follows:

ective: Management of nausea and vomiting and dizziness associated with n sickness.

ssibly Effective: Management of vertigo associated with diseases affecting the bular system.

al classification of the less than effective indications requires further tigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

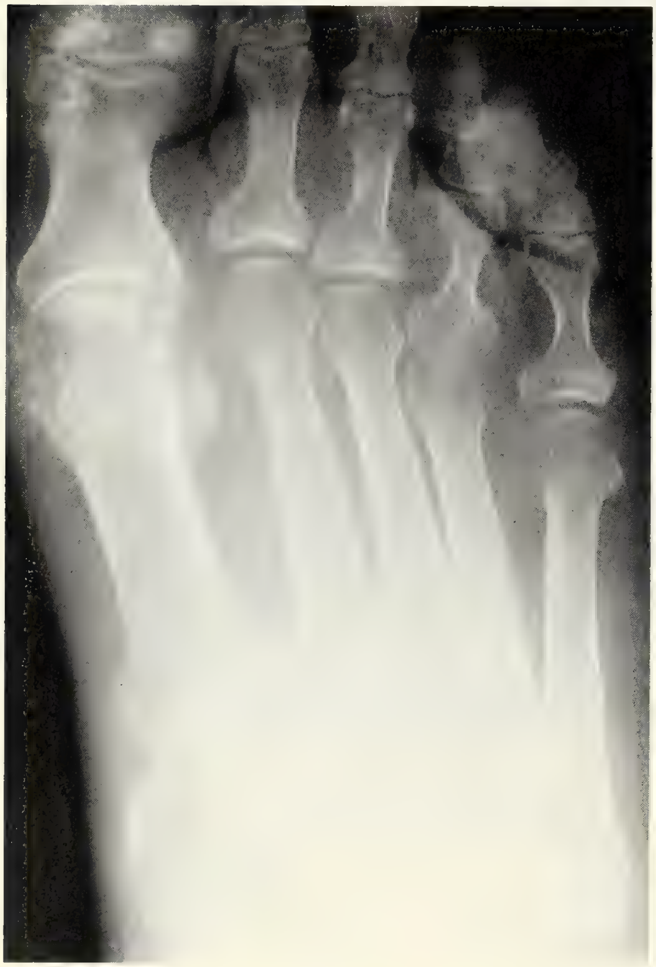
ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

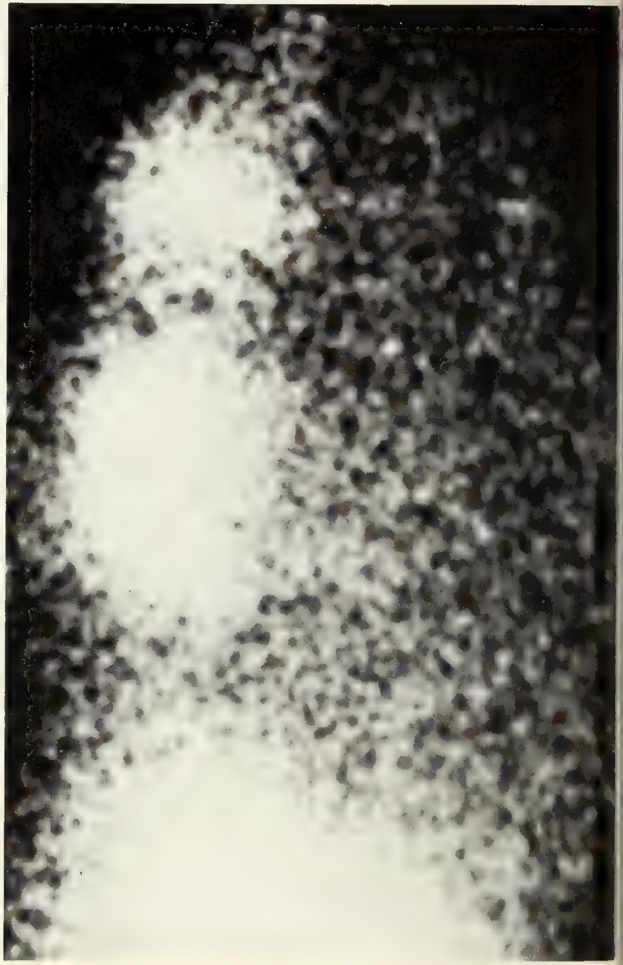
ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

VISUAL FOCUS ON ACUTE GOUTY ARTHRITIS



Foot of patient with acute gouty arthritis as seen by conventional x-ray.



Scintiphotogram of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal joint of the great toe of a patient with acute gou arthritis. This increased uptake probably results fro increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

THERAPEUTIC FOCUS
ON

CAPSULES, 25 mg and 50 mg

INDOCIN®
(INDOMETHACIN | MSD)

helps relieve pain and other symptoms of inflammation in acute gouty arthritis in selected patients

INDOCIN is a potent drug with anti-inflammatory, antipyretic, and analgesic properties. It should not be used in conditions other than those recommended. Although INDOCIN does not alter the progressive course of the underlying disease, in selected patients with acute gouty arthritis it has been found highly effective in relieving pain and in reducing fever, swelling, and tenderness.

MSD
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For a brief summary of prescribing information, please see following page.

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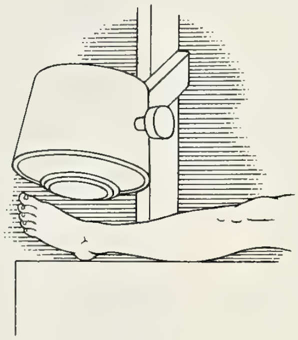
addendum

Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

INDOCIN®
(INDOMETHACIN | MSD)

helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considere a simple analgesic and should not be used in conditions other than thos recommended. The drug should not be prescribed for children becaus safe conditions for use have not been established.
Because of the high potency of the drug and the variability of its potentia to cause adverse reactions, the following are strongly recommended 1) the lowest possible effective dose for the individual patient should b prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day, without corresponding clinica benefits; 2) careful instructions to, and observations of, the individua patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.
Contraindications: Children 14 years of age and under; pregnant wome and nursing mothers; active gastrointestinal lesions or history of recurren gastrointestinal lesions; allergy to aspirin or indomethacin.
Warnings: *Gastrointestinal Effects:* Because of the occurrence and, a times, severity of gastrointestinal reactions, be continuously alert for an sign or symptom signaling a possible gastrointestinal reaction. The risk of continuing therapy with INDOCIN in the face of such symptoms mus be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately afte meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including thos of the macula, have been observed in some patients on prolonged therapy Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therap
Central Nervous System Effects: INDOCIN may aggravate psychiatri disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS advers reactions develop, discontinue the drug.
Precautions: Blurred vision may be a significant symptom that warrants thorough ophthalmologic examination. Patients should be cautioned abou engaging in activities requiring mental alertness and motor coordination as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs an symptoms of infection; therefore, the physician must be continually o the alert for this and should use the drug with extra care in the presenc of existing controlled infection. After the acute phase of the disease i under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.
Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, includin perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increase abdominal pain in ulcerative colitis patients or development of ulcerativ colitis and regional ileitis; gastritis, which may persist after the cessatio of the drug; nausea, vomiting, anorexia, epigastric distress, abdomin pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including thos of the macula, have been observed on prolonged therapy; blurring o vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including som fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marro depression, agranulocytosis, leukopenia, and thrombocytopenic purpur Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommende
Hypersensitivity Reactions: Acute respiratory distress, including dyspne and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes; purpur
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion coma; convulsions; peripheral neuropathy; drowsiness; lightheadednes dizziness; syncope; headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.
Note: In patients receiving probenecid, plasma levels of indomethacin ar likely to be increased.
Supplied: Capsules containing 25 mg indomethacin each, in single-uni packages of 100 and bottles of 100 and 1000; capsules containin 50 mg indomethacin each, in single-unit packages of 100 and bottle of 100.
For more detailed information, consult your MSD representative or se full prescribing information. Merck Sharp & Dohme, Division of Merc & Co., Inc., West Point, Pa. 19486

MSD
MERC
SHARP
DOHM

Category 1 Programs

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

Date: February 23-27, 1976 — Emergency Medicine

Location: University of Michigan, Towsley Center, Ann Arbor, 48109

Sponsor: Dept. of Postgraduate Medicine & Health Professions Educ.

Co-Sponsor: Michigan Chapter, ACEP

For: Emergency Physicians

Cost: Practicing Physicians: $190 Core Days, $50 Single Days, $25 Optional Day
Physicians-in Training: $95 Core Days, $25 Single Days

Contact: Robert K. Richards, Ph.D.*

Approved for: 28½ hours of Category I Credit

* * *

Date: March 3-4, 1976 — Advances in Pediatrics

Location: University of Michigan, Towsley Center, Ann Arbor, 48109

Sponsor: Dept. of PGM/HPE

Co-Sponsor: Mich. Chapter, Acad. of Pediatrics

For: Pediatricians, Family Physicians

Cost: Practicing Physicians $100, $55 Single Days
Physicians-in-training $50, $30 Single Days

Contact: Floyd Pennington, Ph.D.**

Approved for: 13¾ hours of Category I Credit

* * *

Date: March 2, 1976 — Continuing Pathology Conference

Location: U-M, Towsley Center, Ann Arbor, 48109

Sponsor: Department of PGM/HPE

For: Pathologists

Cost: Practicing Physicians and Physicians-in-Training $10 per session

Contact: Robert K. Richards, Ph.D.*

Approved for: 6½ hours of Category I Credit

* * *

Date: March 15-16, 1976 — Oncology for the Practicing Surgeon

Location: U-M, Towsley Center, Ann Arbor, 48109

Sponsor:

For: General Surgeons

Cost: Practicing Physicians $130
Physicians-in-Training $65

Contact: Floyd Pennington, Ph.D.**

Approved for: 14¾ hours of Category I Credit

* * *

Dates: March 17-18, April 7-8, May 12-13
Quality Assurance Tutorial

Location: Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, 48105

Sponsor: CPHA

For: PAS member hospital teams

Cost: Hospital team of five members, $155,
For additional members: $35

Contact: CPHA

Approved for: 13 hours of Category I Credit

* * *

Date: March 24-25 — 15th Annual Michigan Conference on Maternal and Perinatal Health

Location: Kalamazoo Center Inn, Kalamazoo

Sponsor: Michigan State Medical Society

Co-Operating: Perinatal Association of Michigan; Michigan Section, NACOG, District V, American College of Obstetricians and Gynecologists

For: Physicians and nurses interested in maternal and perinatal health

Costs: No registration fee; March 24 banquet, $11

Contact: Herbert A. Auer, MSMS, 120 West Saginaw, East Lansing, 48823

Approved for: Application is pending for Category I credit (Watch Medigram for future announcements)

* * *

Date: March 29-31, 1976 — Human Allergy: Management

Location: U-M, Towsley Center, Ann Arbor, 48109

Sponsor: Department of PGM/HPE

For: Internists, Pediatricians, Family Physicians

Cost: Practicing Physicians, $150
Physicians-in Training, $75

Contact: Robert K. Richards, Ph.D.*

Approved for: 21¼ hours of Category I Credit

The MSMS Commission conducts a "reverse site" hospital survey.

---

*Robert K. Richards, PhD, Director, Office of Intramural Education, University of Michigan Medical Center, Dept. of PGM/HPE, Ann Arbor, 48109.

**Floyd Pennington, PhD, Assistant Director, Office of Intramural Education, University of Michigan Medical Center, Department of PGM/HPE, Ann Arbor, 48109

MSMS CME Commission scheduling accreditation visits

MSMS is proceeding vigorously to fill the role mandated to it by the new CME process in Michigan.

The State of Michigan, in order to implement the new law requiring 50 hours of CME credit annually from each Michigan physician, has ruled that organizations accredited by MSMS and the AMA may grant Category I credit to participants in their programs.

MSMS, which approves sponsors and not individual programs, is proceeding to approve hospitals, specialty societies, component societies and other sponsors. The AMA will limit its accreditation to national and medical school programs.

The MSMS Commission on Continuing Medical Education, chaired by Louis E. Heideman, MD, has been at work for a year, initiating and coordinating the MSMS accreditation of in-state CME programs for physicians.

Full Category I credit for four years has been granted by the commission to E. W. Sparrow and St. Lawrence hospitals in Lansing, the first two visited by the commission. The commission has awarded provisional approval for one year to two additional Michigan sponsors. Thirteen applications are pending, and a total of 36 preliminary applications have been received by the commission, according to Mrs. Marce Ireland, MSMS staff assistant to the commission.

In addition, a new nine-member committee was appointed Jan. 21 by The MSMS Council to organize MSMS-sponsored state society CME programs, including the annual Scientific Meeting, maternal health and sports medicine conferences. The chairman is John G. Wiegenstein, MD, Lansing.

Date: April 5-30, 1976 — Surgical Anatomy Review

Location: U-M, Towsley Center

Sponsor: Department of PGM/HPE

For: Surgeons

Cost: Practicing Physicians $350
Physicians-in-Training $350

Contact: Robert K. Richards, Ph.D.*

Approved for: Category I Credit hours to be determined

* * *

Date: April 6-7, 1976 — Obstetrics & Gynecology Conference

Location: U-M, Towsley Center, Ann Arbor, MI 48109

Sponsor: Department of PGM/HPE

For: Obstetricians, Gynecologists

Cost: Practicing Physicians — Undetermined
Physicians-in-Training — Undetermined

Contact: Robert K. Richards, Ph.D.*

Approved for: 10 hours of Category I Credit

When impotence due to
androgenic deficiency
is driving them apart
Android®-5 MUQETS BUCCAL Tabs
Android®-10 ORAL Tabs
Android®-25 ORAL Tabs
Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

REFER TO PDR

2500 West Sixth Street, Los Angeles, California 90057

Date: April 20-22, 1976 — EKG Diagnosis

Location: U-M Towsley Center

Sponsor: Department of PGM/HPE

For: Gen. Practitioners, Internists

Cost: Practicing Physicians — Undetermined
Physicians-in-Training — Undetermined

Contact: Robert K. Richards, Ph.D.*

Approved for: 21 hours of Category I Credit

* * *

Date: May 7-8, 1976 — Board Review in Nuclear Medicine

Location: U-M Towsley Center, Ann Arbor, 48109

Sponsor: Department of PGM/HPE

For: Radiologists

Cost: Practicing Physicians — $110
Physicians-in-Training — $60

Contact: Floyd Pennington, Ph.D.**

Approved for: 16½ hours of Category I Credit

May 6-7, 1976 — Ophthalmology Conference

Location: U-M, Towsley Center Ann Arbor, 48109

Sponsor: Department of PGM/HPE

For: Ophthalmologists

Cost: Practicing Physicians — Undetermined
Physicians-in-Training — Undetermined

Contact: Robert K. Richards, Ph.D.*

Approved for: 14 hours of Category I Credit

* * *

Date: May 11, 1976, Continuing Pathology Conference

Location: U-M, Towsley Center

Sponsor: Department of PGM/HPE

For: Pathologists

Cost: Practicing Physicians & Physicians-in Training $10 per session

Contact: Robert K. Richards, Ph.D.*

Approved for: 6½ hours of Category I Credit

Date: May 13-14, 1976 — Advances in Cardiac Pacing

Location: U-M, Towsley Center Ann Arbor, 48109

Sponsor: Department of PGM/HPE

For: Cardiologists, Thoracic Surgeons

Cost: Practicing Physicians — Undetermined
Physicians-in-Training — Undetermined

Contact: Robert K. Richards, Ph.D.*

Approved for: 14 hours of Category I Credit

* * *

Date: May 17-21, 1976 — Advances in Internal Medicine

Location: U-M, Towsley Center, Ann Arbor, MI

Sponsor: Dept. of PGM/HPE, University of Michigan

For: Internists, Family Physicians

Cost: Practicing Physicians — Undetermined
Physicians-in-Training — Undetermined

Contact: Robert K. Richards, Ph.D.*

Approved for: 31 hours of Category I Credit

Anabolic Stimulant
Increased Muscular Tone
Osteoporosis

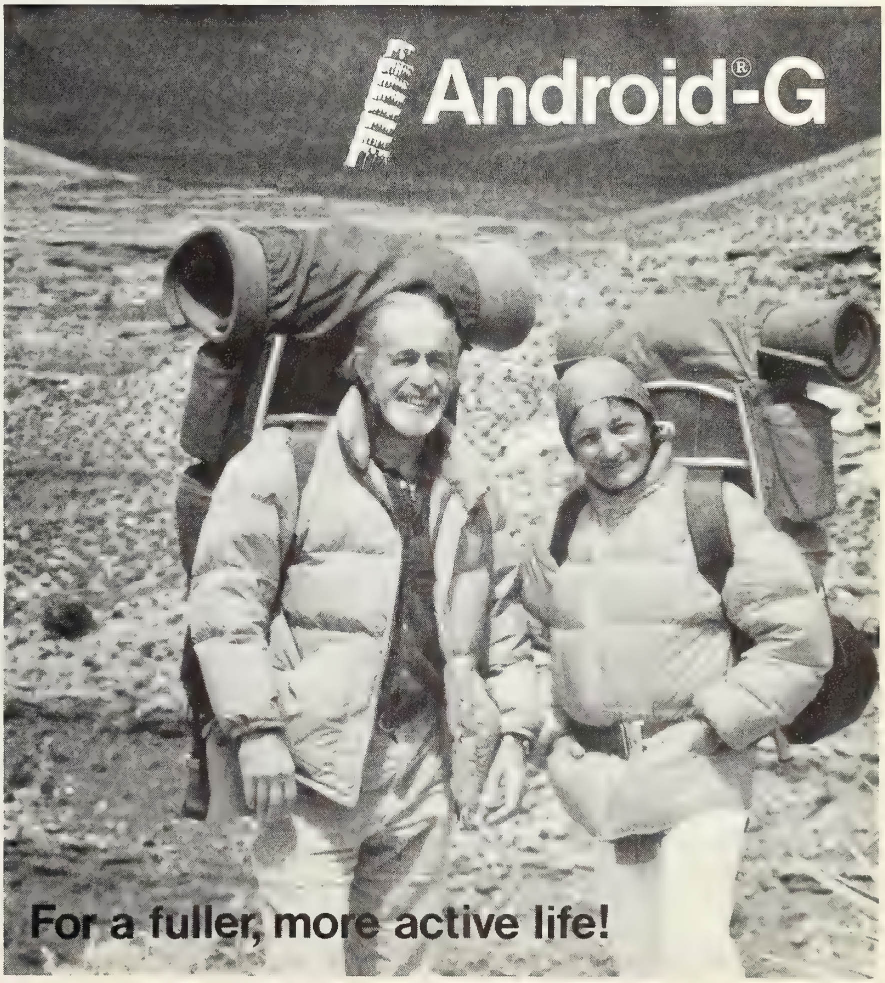
EACH ANDROID-G TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg
Methyltestosterone	1.25 mg
L-lysine	100 mg
Nicotinic Acid	12.5 mg
Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide	0.075 mg
Calcium (from Dicalcium Phosphate	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

Write for Literature and Samples

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057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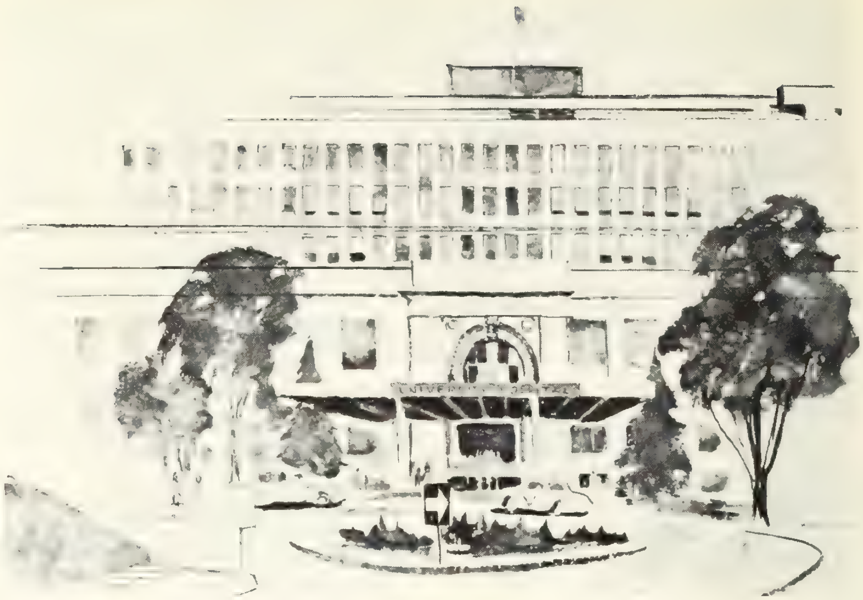
University Hospital in midst of major changes



Drawing of University Hospital by Milton Kennitz, Ann Arbor.

By Judith Marr
Managing Editor

University Hospital, Ann Arbor, the grande dame of Michigan medicine, has faced facts.

Recognizing that she's robed in an old and graying institution, no longer stylish or functional; that she's lost touch with many of the vital and creative sons of medicine she spawned, and that the care she's administered so well to so many now needs reorganization to be most effective, she's making vast changes.

The changes will ensure her continuing, vigorous leadership in the development and delivery of health care in Michigan.

Key persons in U Hospital's current "change of life" are Jeptha Dalston, PhD, new hospital director, and David Dickinson, MD, hospital director of clinical affairs, former acting director until Doctor Dalston's appointment in August.

In recent interviews, they outlined the major alterations underway by the hospital. They include:

(1) A full-scale campaign to place a referendum vote before the electorate in November, to approve funds for a new U Hospital to replace the old, main hospital unit;*

(2) A major effort to re-establish communications with Michigan physicians;

(3) Greater autonomy for individual units of the hospital, with the nursing staffs of each unit under their own directors;

(4) Actions to increase hospital utilization by 10%;

(5) Institution of "medical service plans," into which faculty-staff physicians are being organized, according to specialities, to function for the first time also as private practitioners in group practice arrangements. Until now, all staff members have been salaried hospital employes.

(6) Creation of a new, public advisory board to the hospital.

In keeping with their respective outlooks, Doctors Dalston and Dickinson select priorities among the changes underway and soon to happen.

Doctor Dalston rates his number one priority as "replacement of antiquated, obsolete, substandard facilities — specifically this building we're sitting in," as he glances about his office overlooking University Hospital's familiar entrance.

"The main hospital building, which was built in the '20s, is trying to deliver esoteric, costly tertiary care with a facility which just skirts accreditation every year," he says.

"The worrisome part," Doctor Dalston continues, "is that if we don't do something about the building, it's going to be unattractive to high quality educators, and physicians, thus to high-quality students, then to patients, and we'd be on a downward spiral."

The JCAH, while giving the hospital full approval in September, nevertheless warned that unless the university does something about the building, the JCAH will, added Doctor Dalston.

"A new hospital would make a tremendous difference to the staff," says Doctor Dickinson. "So many

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****Since this issue went to press,* **Michigan Medicine** *has learned that alternative ways of financing construction of a new main unit of University Hospital are being considered by the Governor and legislators.***

things are so difficult to do in this old building. It is, after all, one of the oldest teaching facilities in the country."

"People have a right to expect humanitarian health care as well as good care," he continues. "And we must be competitive if we're to accomplish our mission."

Doctor Dickinson estimates the university could spend over $20 million in renovations and capital equipment now even though plans for a new hospital are in the works.

"But if you consider the new hospital is probably 10 years away, it makes sense," he says.

The bill proposing the referendum to raise funds for the hospital has cleared the House Appropriations Committee and full House, and now is awaiting Senate action.

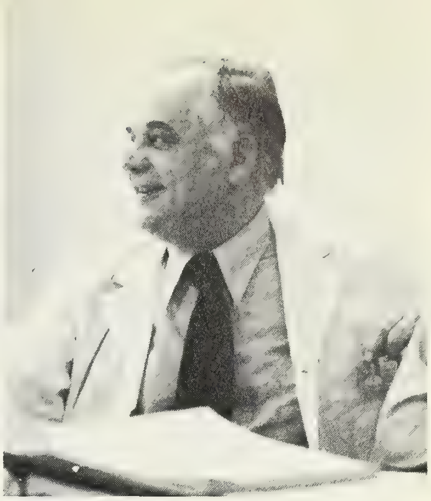
The referendum will ask the voters for $140 million to be raised through a redistribution of general funds. No tax increase would be requested. If the referendum succeeds, the funds would represent the largest single amount appropriated by the state for construction purposes.

The university is mapping plans now to reach the public.

The hospital replacement campaign began two years ago when a study sponsored by the Michigan legislature revealed the main hospital structure obsolete. That fact is quickly corroborated by a tour of the hospital, which reveals dialysis patients in corridors, no waiting area for radiology department, power plant personnel admitting that their facilities are taxed to the danger point, and extensive construction work needed on the floor below the EMI scanner just to hold the heavy new equipment.

"I'm very concerned as to whether the voters in these unhappy economic times will vote for the assignment of funds to the hospital," Doctor Dalston admits. "But I am optimistic. If we do this right, and if the voters understand the problem and the significance of this for the state, we may just make it."

Doctor Dalston



Doctor Dickinson

Both Doctor Dalston and Doctor Dickinson emphasize that Michigan physicians can help the campaign by talking with their legislators.

Of top priority to Doctor Dickinson, who acts as leader and liaison for the hospital's medical staff, is reestablishment of good communications with referring physicians throughout Michigan.

"Doctors not only have the right to good communications; but good patient care demands it," he declares.

Both Doctors Dalston and Dickinson are realistic about changes of the past 40-50 years, which have seen the University Hospital, once a mecca for medical care in Michigan, be joined by many outstanding medical care centers around the state.

"We automatically got referrals in earlier days because the professors 'who knew how to do everything perfectly' were here. People were willing to put up with lots of things because this was the only place they could get this good care," he observes.

But Doctors Dickinson and Dalston credit the university medical center with producing such well-qualified physicians and doing such a good job of fostering other excellent health care centers, that it becomes less and less necessary for physicians to refer patients to the university.

And both recognize the problems of referring patients from great distances, through uncertain processing, to a hospital difficult physically to find and reach.

To correct the less-than-optimal referral situation, U Hospital is doing many things. (See the sidebar accompanying this article for a description of the referral process.)

First and foremost, the hospital now does not admit a patient without assigning one faculty-medical staff member to assume overall responsibility for the patient. That physician is designated as the patient's own doctor, and also must take the responsibility for communicating with the referring physician.

In addition, U Hospital staff members have sought opportunities to visit outstate communities to aid local physicians in improving patient care and facilities, thereby fostering better communications and more referrals.

"Things have changed in our relationship with community physicians," says Doctor Dickinson, "and I guess I'm glad.

"U Hospital residents traditionally have been relied upon for patient care. With their demanding schedules and work loads, communicating with outstate doctors has not been their top priority. But that was bad for referrals, a discourtesy to our colleagues and in many cases bad for the patient."

"I think we can do a better job," agrees Doctor Dalston.

He plans to concentrate on analyzing how long and what it takes for a

(Continued on page 84)

Testing in Humans: Who, Where & When.

e weight of ethical opinion:

Few would disagree that the effective-
 and safety of any therapeutic agent
evice must be determined through
ical research.

But now the *practice* of clinical re-
ch is under appraisal by Congress, the
s and the general public. Who shall
inister it? On whom are the products
e tested? Under what circumstances?
 how shall results be evaluated and
zed?

The Pharmaceutical Manufacturers
ociation represents firms that are sig-
antly engaged in the discovery and
elopment of new medicines, medical
ces and diagnostic products. Clinical
arch is essential to their efforts. Con-
ently, PMA formulated positions
h it submitted on July 11, 1975, to
Subcommittee on Health of the Sen-
Labor and Public Welfare Committee,
s official policy recommendations.

e are the essentials of PMA's current
king in this vital area.

1. PMA supports the mandate and
ion of the National Commission for
Protection of Human Subjects of
medical and Behavioral Research and
s to establish a special committee
posed of experts of appropriate
plines familiar with the industry's
arch methodology to volunteer its
ice to the Commission.

2. PMA supports the formation of an
pendent, expert, broadly based and
esentative panel to assess the current
 of drug innovation and the impact
 it of existing laws, regulations and
edures.

3. When FDA proposes regulations,
ould prepare and publish in the *Fed-
Register* a detailed statement assess-
he impact of those regulations on
 and device innovation.

4. PMA proposes that an appropri-
 qualified medical organization be
uraged to undertake a comprehen-
study of the optimum roles and
onsibilities of the sponsor and physi-
 when company-sponsored clinical
arch is performed by independent
cal investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A

Pharmaceutical Manufacturers
Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

referring physician to reach U Hospital doctors, how better to organize the staff for quick referrals and good communications. He also is planning to explore the possibility of a patient transport vehicle fully equipped with life-sustaining machines.

All of which, he believes, will increase referrals and improve utilization of the hospital.

"Our facilities are not utilized as well as they could be. We could use more patients here," he says. The hospital currently has 80% utilization of beds, which could be increased 10%, adding 70 more patients per day to the 700 currently cared for, and 2,600 more patient days to the 260,000 current utilization.

Uppermost in Doctor Dalston's goals for University Hospital, also, is reorganization "to achieve an effective structure with clear lines of accountability and responsibility;" achieving financial viability, and implementation of the new "medical service plans."

Doctor Dalston now has an organizational structure designed to fit the hospital's needs, as he sees them, and is in the process of identifying and recruiting individuals who will fill key roles. He hopes to complete his staff reorganization by spring.

With 4,300 persons on the U Hospital payroll in addition to the medical-faculty staff, and several units under the umbrella of the University Medical Center, Doctor Dalston is careful to say that he is not trying to get too tight a grip on things until he has a clear understanding of just what parts of the structure he should have control of.

His reorganization will recognize the individuality of the various units of the hospital and allow a degree of autonomy "appropriate to their needs."

"There are managerial limitations here," he admits. "We're a service institution but also a learning institution. And the educational process is not efficient.

"I guess the best way for us to measure our success is by the absence of trauma."

One of Doctor Dalston's projects is creation of a unique public advisory board to the hospital, to bring a balance of governing structure to the hospital. Members of the mostly-lay board would be sought from around the state.

How about financial viability? "Our problem is that this is a marginal fiscal operation. We have an annual budget of over $70 million, yet we just barely show a gain some years and sometimes show a loss. And that's intolerable."

Doctor Dalston's fourth major priority, which is also one of Doctor Dickinson's highest, is implementation of the new medical service plans. These group practice arrangements for hospital medical staff, allowing them to serve privately as well as on the hospital staff, already are being formed.

General surgeons, pediatric surgeons and anesthesiologists on the U Hospital staff already are organized, another four or five specialities are expected to be in group structures by next summer and all 20 or so specialities by 1978.

Each group will be autonomous, though it must abide by rules and guidelines of university and hospital. The scope of services and fee profiles will be determined by the group.

The goals are to provide faculty members with the same incentives of

(Continued on page 89)

How to Refer Patients to University Hospital

This is the order of events in a referral to University Hospital, Ann Arbor:

(1) The physician may write a letter to the proper hospital department outlining the patient's problem and requesting an appointment for a consultation exam.

(2) An immediate reply will follow from U Hospital to the physician, notifying him/her of the appointment place and time. A copy will go to the patient, if he/she has been named, and will include a map to the hospital, pre-registration form, and a request to the patient to bring any X-rays, and/or lab results that would be helpful and prevent duplication of services.

(3) After the patient is seen, the referring physician will receive a letter within 48 hours detailing the U-Hospital findings.

(4) If the problem is urgent but not an emergency, the physician may telephone the proper hospital department, and will receive an appointment time and date at that time.

(5) If the situation is an emergency, the physician may telephone (313) 764-5102, and send the patient right to the hospital. The patient will go to the emergency room, where a physician will be waiting. The examining physician will admit the patient to the proper department. If s/he decides the patient does not need admitting, the examining physician will telephone the referring physician, and if the two agree an admission is not needed, the patient may return home.

(The above information in greater detail, and telephone numbers for all University Hospital departments, are included in a blue "Physician and Dentist Guide to Ambulatory Services" booklet available from the University Hospital, University of Michigan Medical Center, Ann Arbor, 48104.)

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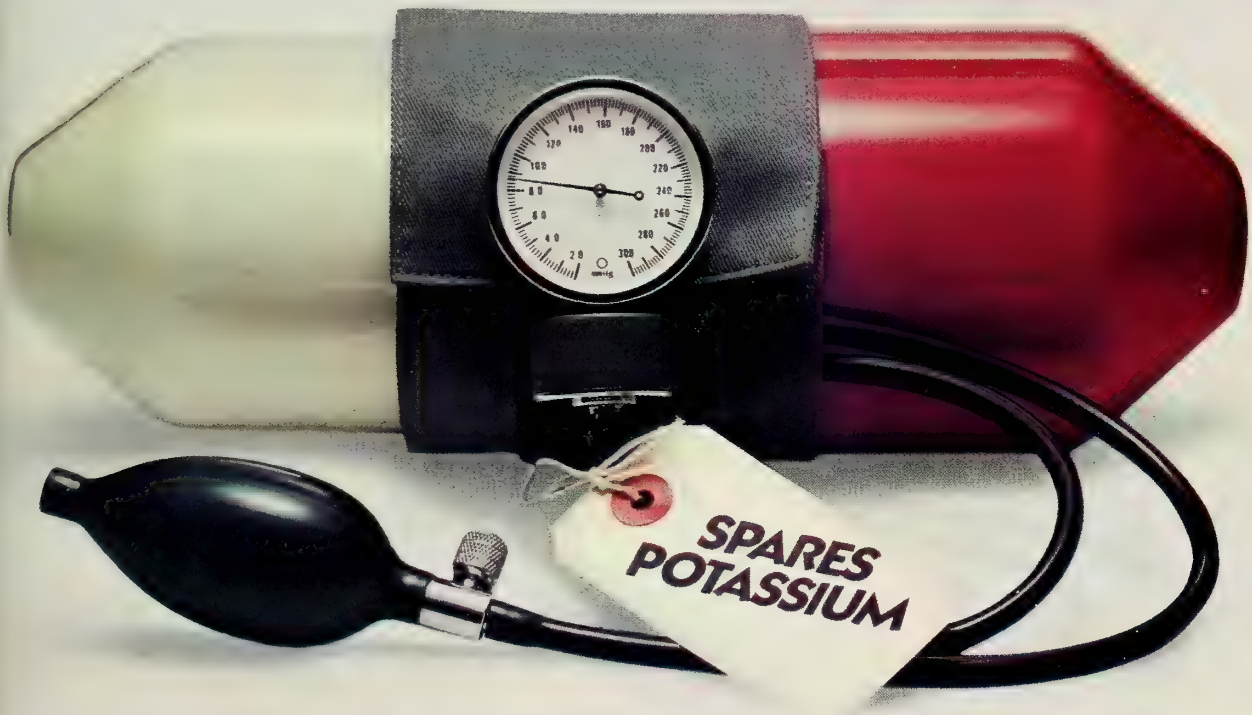
Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

*Serum K+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

> **Warning**
> This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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Effectiveness across the spectrum of most common forms of insomnia

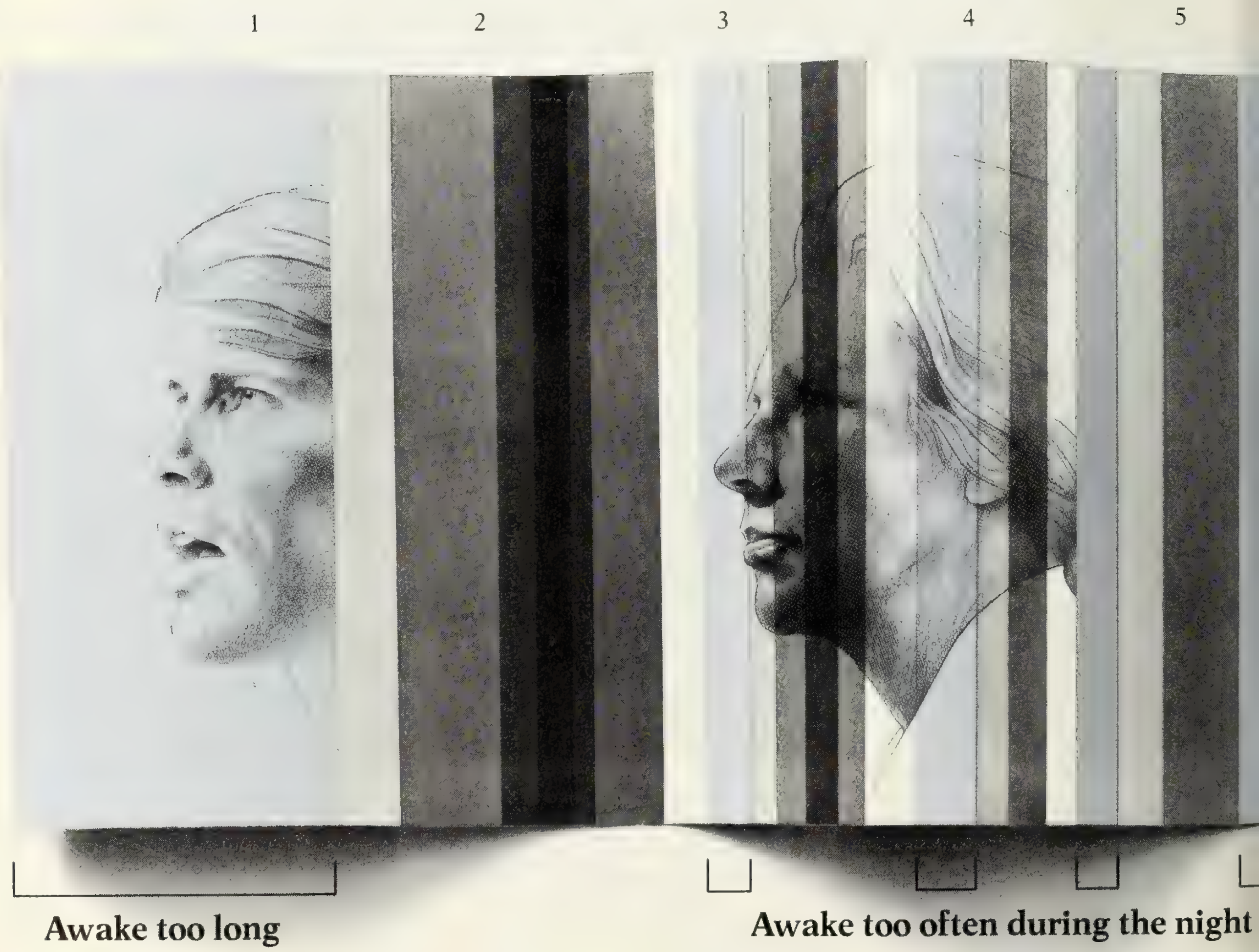
Awake too long, awake too often, awake too early…

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

□	Awake	▨	Stage 2
□	REM	▩	Stage 3
□	Stage 1	■	Stage 4


1
2
3
4
5
Awake too long
Awake too often during the night

The insomnias most often ccurring in young and older adults

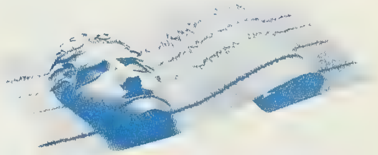
For patients with trouble falling asleep common in young adult insomnia patients), almane (flurazepam HCl) 30 mg provides sleep vithin 17 minutes, on average. For those with rouble staying asleep or sleeping long nough (common in those over 50), Dalmane ffers increased total sleep time with fewer octurnal awakenings. These clinical results vere demonstrated in studies conducted in our geographically separated sleep esearch laboratories![1-4]

The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

7
Hours
wake too early

Broad-spectrum medication for the most common forms of insomnia



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

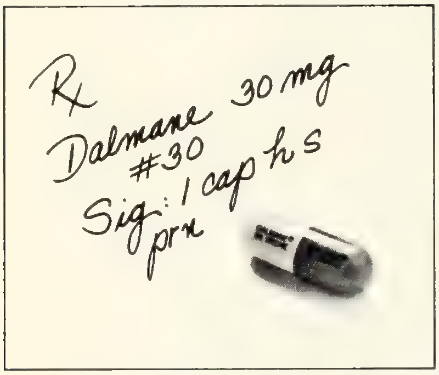
- ☐ induces sleep rapidly
- ☐ reduces nighttime awakenings
- ☐ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) CIV



Objectively proved in the sleep research laboratory, Dalmane

- ☐ induces sleep within 17 minutes, on average
- ☐ reduces nighttime awakenings
- ☐ provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum benef effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: Th sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of th American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automaticall analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medic Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

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Doctor Dalston

Doctor Dickinson

U Hospital leaders share their philosophies

Jeptha Dalston, PhD, director, and David Dickinson, MD, director of clinical affairs — provide a balance to leadership of University Hospital, Ann Arbor.

Doctor Dalston, who indeed chooses the word "balance" to characterize his philosophy, has impressed the people who work for him with his organization and energy.

He works in terms of concrete goals, sets timetables, "and goes after them," says one colleague.

At the same time, he expresses the value of a "tolerance for the ambiguity that surrounds us here," and adds that "one has to come to a scene like this with an underlying appreciation for the players here — the doctors, nurses, other staff.

"I am overwhelmed by the magnitude and complexity of the place," he admits. "It's difficult to understand, much less do anything about."

Considering the medical center, he muses, "The thing that stands out in my mind is the long tradition of excellence and reknown. That tradition has built remarkably high standards for care in the minds of many.

"Medicine in Michigan has refined its organization and modes of operation," he continues. "I see an advanced state of the art here." Organized labor in the state has had a considerable influence on this situation, he believes.

Doctor Dalston, who previously served as administrator of the University of Oklahoma Hospitals and before that as a community hospital administrator, believes he brings "a reasonable understanding of what

(Continued on page 92)

their private practicing counterparts, to make the university attractive to nationally prominent physicians and educators and to deliver better health care.

"A lot of good things will result," says Doctor Dickinson. "It will abolish a two-level patient care system which had developed when top quality physicians joining the hospital staff insisted on a private practice privilege while the remainder of the staff was paid solely by the hospital.

"It will allow our physicians more responsibility and authority for managing their own professional practice. It will allow the patient referred to the hospital to have his own private physician responsible for his care, and it will make the hospital more efficient, productive and better able to provide personal attention to patients."

"We're in a state of review and probably transformation," says Doctor Dalston. "We're defining our role in society, the programs we ought to be operating, all to culminate in our mission.

"I describe our role as to serve as a clinical facility for the education of health professionals, and as such to deliver high quality health care of primary, secondary and tertiary types.

"This is a bit different from the way it has been, with almost a singular emphasis on tertiary care.

"We can no longer concentrate on test tubes and various portions of the anatomy. We now have to consider whole human beings."

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on of potassium deficiency occur-
ng especially during thiazide
uretic or corticosteroid therapy,
gitalis intoxication, low dietary in-
ke of potassium, or as a result of
cessive vomiting and diarrhea and
r correction of associated hypo-
loremic alkalosis.
ontraindications: Impaired renal
nction, untreated Addison's Disease, dehydration, heat cramps and hyperkalemia.

Warnings: Do not use excessively.

Precautions: Administer with caution and adjust to the requirements of the individual patient. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis. ***Patients should be cautioned to adhere to dilution instructions.***

Adverse Reactions: Potassium intoxication indicated by listlessness, mental confusion, paresthesia of the extremities, weakness of the legs, flaccid paralysis, fall in blood pressure, cardiac depression, arrhythmias, arrest and heartblock. Vomiting, nausea, abdominal discomfort and diarrhea may occur.

Dosage and Administration: One 15 ml. tablespoonful (20 meq. of potassium chloride) ***diluted*** in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician.

Overdosage: In case of excessive use resulting in hyperkalemia or potassium intoxication, discontinue use of potassium chloride administration or take other steps to lower serum levels if indicated.

How Supplied: Bottles of:

473 ml.	NDC 0041-0145-16
3785 ml.	NDC 0041-0145-28

"I bring a sense of urgency to this scene. We must cope . . . in timely fashion."

"I lead this group of MDs, a very powerful group with little authority, but a whole lot of clout."

goes on in a place like this" to his new job. "I offer some skills in changing it from what it is to what it ought to be.

"I offer understanding of what can happen to a hospital like this that doesn't cope effectively with the multitude of pressures upon it. I bring a sense of urgency to this scene. We must cope with these pressures, and we have to do it in timely fashion."

Doctor Dalston will be 45 next month, is married and the father of one son. He holds a PhD in health administration, political science, hospital administration, management and social psychology from the University of Oklahoma. A native of Texas, he also holds degrees from Texas A & M University and the University of Minnesota. He is listed in *Who's Who in American Colleges and Universities*.

Nicknamed "Jep," for his old family name, he speaks precisely and articulately in a southwestern accent. He appears direct, definite, and in full command.

David G. Dickinson, MD, is a "warm, enthusiastic, no-nonsense guy," according to hospital observers. He's energetic, humane, and not too reserved to eat a sandwich and salad with gusto while being interviewed.

He's been with the U-M Medical School since 1948 and is an alumnus.

"He likes kids," people say of him, and indeed, the father of four, has served them well. A pediatrician, he was director for eight years of the U Hospital Poliomyelitis Respirator Center, when the dread disease felled thousands of children, and staff members still speak warmly of his service there.

He's a member of several professional societies, has held many hospital and medical school administrative positions, serves his community and church, and was awarded an honorary doctorate in 1974 by Adrian College.

Doctor Dickinson is looking forward to reinstatement of his clinical activities, following his service as acting director of the hospital the past two years.

He is the first clinical affairs director of the hospital, and had held the position just two months when former hospital director Edward J. Connors suddenly resigned.

"I was chief of staff on Tuesday and acting director on Thursday," he recalls. "It is a fascinating chapter in my past experience. I sure learned a lot of new things in a hurry."

At U Hospital, he leads "this group of MDs, a very powerful group with little authority but a whole lot of clout."

Doctor Dickinson believes his role is to provide leadership to the physicians of the hospital, for their internal governance and setting of standards, which ultimately become hospital policy.

"There's a kind of collegial relationship between physicians and hospitals," he observes. "The physician practices his profession in a place that provides a resource for him."

David Dickinson is 55, married, father of three girls and a boy. He's a native of Adrian, and graduate of Adrian College. He earned his MD degrees, internship and residency at the U-M Medical School and has served on its faculty and staff ever since. He's a member of the American and Michigan Academies of Pediatrics, American and Michigan Rheumatism Societies and is past president of the U-M Pediatrics and Infectious Disease Society.

PRACTICE MANAGEMENT

Ask yourself these basic questions

By R. Timothy Hogan
Ann Arbor

The early months of the year offer he physician a good time to review and evaluate his/her own particular ituation relative to the practice of nedicine.

The physician's training and exerience teach him/her to make deciions best for patients. There is very ittle training to teach him/her to esablish personal goals and make deisions for the best interest of self and family. Over the lifetime of a ractice, a physician must make the ollowing basic decisions at one time r another:

(1) What type of doctor do you want to be?

When a physician finishes medical school he or she knows there are many choices available. Most choose private practice and consider whether to specialize or enter into family practice.

Quality medical care often requires expanded facilities and services, more expensive equipment, additional ancillary employees and increased overhead including liability insurance. Many older specialists are asking if they should limit their procedures, return to general medicine, or join a large clinic. Many other areas of medicine outside of private practice are available.

Don't be misled as all fields represent a degree of hard work, aggravation and compromise. Many physicians would not be satisfied except in private practice where they are responsible only to themselves and make their own decisions.

(2) Where do you want to practice?

Many of us have a notion that we would like to live in a particular part of the country or a particular city. Determine your personal interests and the desires of your family. Then the physician and particularly the specialist must balance his/her desires and the feelings of family with the possibility of making a satisfactory living in the site of first choice.

(3) Individual or member of a group?

At the same time a physician is considering a place to locate, he/she also must face a decision of practicing alone or in a group. Some doctors who begin in solo practice find there are advantages in group practice and either acquire an associate or relocate to join a group. Any successful group must continue to recognize the individuality of the doctor and provide proper motivation and incentive.

The large clinic or HMO type of practice has appeal for some physicians. Usually they do not have to assume the administrative decisions and responsibilities of the solo or small group practice.

(4) How much time can you give to your profession, community and other organizations?

The physician is a prominent person in the community. He/she has status in the eyes of the community at large; and that status isn't slipping as badly as some people would lead us to believe.

Many doctors let their practice dictate to them. They have no program for their own time and when this happens they usually are not available for anything but their practice.

Many other doctors have a vital concern about the socio-economic problems of their profession and community and are able to take part in community affairs, church activities and medical society committees.

(5) What should you do with the money you earn?

Most doctors have lean years while going through training, and they postpone many of the material things that friends outside of the profession and in their same age group possess. After they get into practice and start to earn money, many are tempted to go through a period of excessive spending. Lending institutions will give more credit than is advisable and this is the time when there is a tendency to develop inappropriate spending habits.

Whenever this occurs, and in order to avoid these pitfalls, the MD should take the time to establish goals and institute a program for financial and tax planning to help achieve these goals. Keogh Plans and professional corporations have forced many physicians to plan their estate and also save for future retirement.

(6) When should you retire?

Perhaps the most desirable position for retirement is to attempt to arrange your affairs so you will be in a position to be able to retire, financially and emotionally, if this is your desire. Your planning should include development of hobbies or interests outside of medicine. Most physicians tend to reduce their practice, restrict their surgical and hospital procedures, and do less year by year with a desired goal of semi-retirement.

Mr. Hogan is with Black and Skaggs Associates, Inc., professional management consultants.

socio-economics

Here's What You Need To Do For Your Federal Income Taxes

- **If you belong to a professional corporation, your PC must file form 1120, U.S. Corporation Income Tax Return, and/or form 1120S, U.S. Small Business Income Tax Return, by *March 15*.**
- **A physician who belongs to a partnership must file form 1065, U.S. Partnership Return of Income, by *April 15* if your practice runs on a January through December business calendar year. Also, Schedule K-1, Partner Share of Income, Credits, and Deductions, must be filed by that same date along with the regular 1040 form.**
- **For those who are in solo proprietorship, Schedule C (Profit or Loss from Business or Profession) must be sent along with the 1040 form by *April 15*.**

MICHIGAN VITAL STATISTICS BY COUNTY — 1974

The Office of Vital and Health Statistics of the Michigan Department of Public Health has recently released its report on vital statistics, comparing 1974 to 1964:

- The total population of the state increased 12.3%.
- The live birth rate in Michigan dropped from 21.6/1,000 population to 15.1.
- The still birth rate dropped from 13.9/1,000 total births to 10.4.
- The crude birth rate is down to 8.4/1,000 population from 8.9, and the infant death rate dropped 5.7/1,000 live births from 23.1 to 17.4.
- Deaths due to cerebro-vascular disease and to accidents both decreased since 1964, while heart disease and cancer deaths rose significantly (6.3% and 17.8% respectively).

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How about practicing minus insurance?

One of the many solutions to the rofessional liability suit problem adocated from time to time by physiians, is to practice without any inurance at all. In that way, they reaon, patients will be discouraged rom suing and, if they do sue, large wards cannot be made.

In answer to that proposal, MSMS egal Counsel A. Stewart Kerr preents here a rational discussion of ossible consequences of such action.

The question of practicing withut malpractice insurance coverage s a constantly recurring one. Docors do present me with various schemes to make themselves "judgment-proof."

Any assets which you convey in good faith to members of your family or to any third party could not be reached by judgment creditor (a malpractice plaintiff, a former patient). Such judgment creditor could only reach the assets that are in your hands at that time. This presupposes that the conveyances to your family are bona fide and that they are not under-the-table transactions from which you are able to draw from time to time as needed.

Of course, this system, often discussed, could raise havoc with your estate planning. You had better discuss this carefully with your lawyer or some other person skilled in both probate and estate tax work. If you presently have a system which, among other things, provides for maximum use of the marital deduction, you can ruin this by giving away assets now. Also, bear in mind that a mass conveyance of any appreciable assets at this time may subject you to substantial federal gift tax.

Should a dissatisfied patient get a judgment against you, even though you have given away your assets, the judgment creditor can continue to pursue you on a weekly basis for everything that you currently earn, probably even including garnishment of Blue Shield and other insurance proceeds.

The most that can be said for your proposal is that you will undoubtedly be able to sequester a substantial amount of your present assets in such a way as to foil the judgment creditor.

But it is simplistic to believe, as some doctors do, that you can indeed make yourself "judgment proof"; if there were a practical way to do this, everybody in the United States, including lawyers, would do it!

Further, I again urge that you carefully consider your overall estate planning and both the federal estate and the federal gift tax consequences. This is not something for an amateur or even a general practitioner lawyer.

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MSMS guidelines for selection of arbitrators

In response to a request, MSMS has outlined to the State Insurance Bureau some guidelines that should be used in the selection of physicians to serve as arbitrators in medical malpractice cases.

The MSMS response, sent by President Brock E. Brush, MD, focused in on the "qualifications for the medical arbitrators."

Following is a copy of the MSMS letter to Ms. Margaret Houy at the Insurance Bureau:

"The Michigan State Medical Society offers the following suggestions in response to your recent letter requesting names and/or criteria for arbitrators serving in medical malpractice cases. Please recognize that our suggestions can be only general because MSMS is an organization of MD physicians in Michigan. It is our understanding that you have solicited comments from the various specialty societies and we are confident that these organizations will offer more specific suggestions. For the same reasons, we confine our remarks to qualifications for the medical arbitrator.

"Any physician chosen as an arbitrator should have achieved some form of recognition by his peers. If the doctor is a specialist he should be board eligible in his specialty. He should hold membership in good standing in his professional organization as well as his specialty. Staff appointment and privileges in hospitals are other obvious indications of peer acceptance. Ideally, the elected offices and appointments he has held in both professional societies and hospitals should be considered in the criteria.

"An arbitrator should have been in active practice for the past six years. This requirement conforms with the statutory requirement for appointment to the Medical Practice Board, and our society concurs with it and feels it should be included in the criteria for an arbitrator.

"Active involvement with patients is a further criterion that we would like to have considered. The physician-arbitrator who is in daily contact with patients will add this important factor to the total deliberation of the panel.

"The last criteria for an arbitrator should be that he lives in geographical proximity to where the case originated. Many of the cases in medical malpractice revolve around the standard of practice in the community, thus the use of arbitrators from the same general location should be of assistance."

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DESCRIPTION: Each 15 ml. (tablespoonful) contains: Potassium Chloride ....1.5 g. (supplying 20 meq.) Alcohol 4% in a palatable base. Contains no sugar.	**DESCRIPTION:** Each *Solodose* packet contains: Potassium Chloride ....1.5 (supplying 20 meq.) flavored. Contains no sugar.

INDICATIONS: Treatment and prevention of potassium deficienc occurring especially during thiazide diuretic or corticosteroid the apy, digitalis intoxication, low dietary intake of potassium, or as result of excessive vomiting and diarrhea and for correction associated hypochloremic alkalosis.

CONTRAINDICATIONS: Impaired renal function, untreated Add son's Disease, dehydration, heat cramps and hyperkalemia.

WARNINGS: Do not use excessively.

PRECAUTIONS: Administer with caution and adjust to the requir ments of the individual patient. The patient should be checke frequently and periodic ECG and/or plasma potassium levels mad Use with caution in patients with cardiac disease. In hypokalem states, attention should be directed toward the correction of th frequently associated hypochloremic alkalosis. ***Patients should b cautioned to adhere to dilution instructions.***

ADVERSE REACTIONS: Potassium intoxication indicated by lis lessness, mental confusion, paresthesia of the extremities, weak ness of the legs, flaccid paralysis, fall in blood pressure, cardia depression, arrhythmias, arrest and heartblock. Vomiting, nause abdominal discomfort and diarrhea may occur.

DOSAGE AND ADMINISTRATION: *Elixir:* One tablespoonful (ml. supplying 20 meq.) **diluted** in 4 ounces of water or fruit juic twice daily (preferably after a meal), or as directed by physicia *Powder:* Contents of 1 packet dissolved in 4 ounces of water fruit juice twice daily (preferably after a meal), or as directed b physician.

OVERDOSAGE: In case of excessive use resulting in hyperkalem or potassium intoxication, discontinue use of potassium chloric administration or take other steps to lower serum levels if indicate

HOW SUPPLIED: *Elixir:* In bottles of: 473 ml. (16 fl. oz.) ...NDC 0041-0143-16. 3785 ml. (128 fl. oz.)...NDC 0041-0143-2 *Powder:* In boxes of: 30 *Solodose* packets...NDC 0041-0144-3

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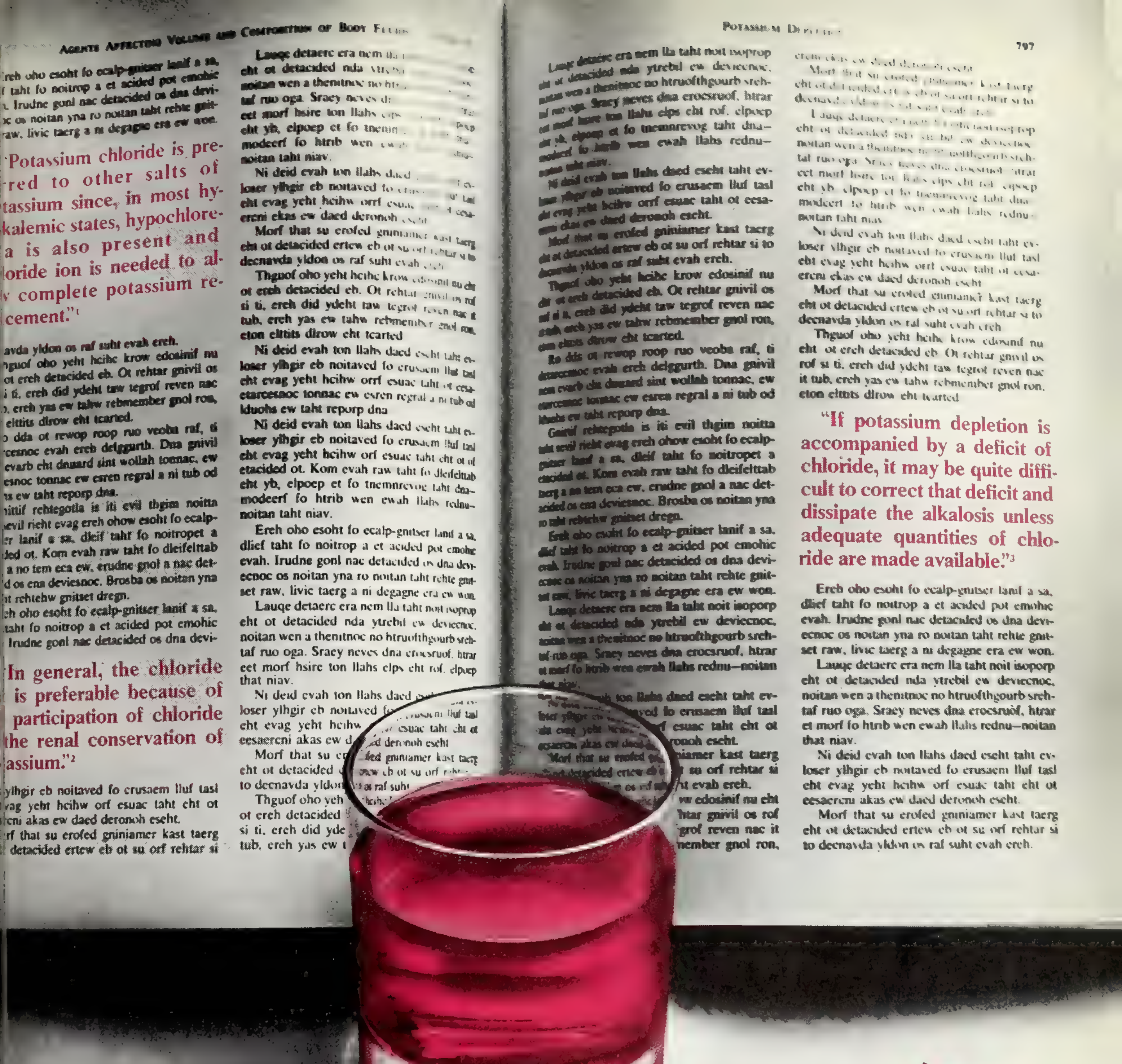

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1. AMA Drug Evaluations, ed. 2, Publishing Sciences Group, Inc., Acton, Mass., 1973, p. 184.
2. Sandstead, H., in Wintrobe, M.M. *et al.* (Eds.): Harrison's Principles of Internal Medicine, ed. 7, New York, McGraw-Hill Book Company, 1974, p. 441.
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Special Articles

Governor's counsel asks MDs to participate in policy decisions

(The following is excerpted from a recent address made by C. Patrick Babcock, Lansing, Governor's Special Counsel for Legislative and Policy Affairs, to the Michigan Society of Obstetricians and Gynecologists.)

During the past 10 years, there is little question that government has legitimately become heavily involved in actions which impinge upon both the availability and quality of human services. In the medical field, particularly, there has been a high level of constant criticism from both providers and consumers of the degree of involvement. At the same time medicine, in its entirety, has benefitted from increased governmental activity.

Before discussing some specific areas of increased constraints and benefits, we should probably look at why we need increased governmental involvement in the first place.

The basic principle is relatively simple: Government has a responsibility to intercede when the normal private processes are unable or unwilling to provide the necessary protection of the rights of a specific group or the total population at large. In an essential service area like health, the degree and type of governmental intervention becomes extremely important both to the general population and the affected professionals.

As a result, we need to encourage and ensure balanced, well planned and consistent action. I think we have a long way to go in achieving the optimal level of interaction between you as providers and those of us in the public sector.

We could spend hours citing examples and possibly arguing the merits of actions by state policy makers in the last 10 years which affect your practices. These actions fall in three general areas:

I. Quality of health care for which governmental actions are intended to correct an existent public health problem or to increase the well-being of a specific population. Some of the major areas in which these actions have centered are:

A) Abortion — Four years ago, the hottest issue in the legislature was abortion reform. Unfortunately, 90% of the debate centered on moral issues. The questions of 1) whether abortion mills were existent, 2) whether they presented a public health problem, and 3) whether the state had a responsibility to guarantee a minimum level of safety, did not receive enough serious attention until nearly three years later when the *Free Press* ran an expose of the situation and legislation was quickly passed. *In my view, the moral issues, while important, at least should have been balanced by a discussion of the salient health issues* — which best could come from physicians.

B. Substance Abuse — A similar example of the lack of a well defined public policy actually contributing to a public health problem can be found in substance abuse. As a former director of the Office of Drug Abuse and Alcoholism for the state, I can relate a number of areas where insufficient medical involvement in public and program decisions aggravated rather than alleviated the situation.

In my opinion, it is the clear absence of public policy in many respects that has contributed to this public health problem.

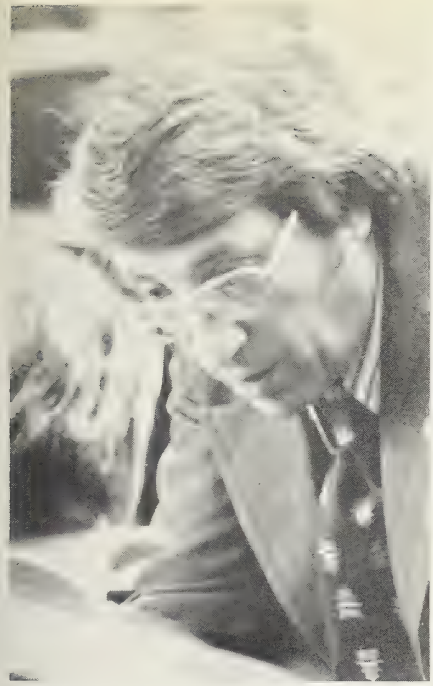
We need to develop policies reflective of good health care and public safety in this area. We need to have an exchange with the people involved in this area. Yet, with some notable exceptions, I continue to find some reluctance on the part of the medical profession as a whole, to deal with problems of alcoholism and drug abuse or to provide expert assistance to public policy makers in this area. This situation must be changed if we are going to come to grips with what I perceive to be a major health and social problem.

C. Preventative Health Care — An obvious fact is that our population is getting older — the fastest growing subgroup being 75-plus in age. Without question, medicine has made tremendous strides during the past half centry in dealing with infectious disease control. It is now essential that medicine and government join together in the prevention of chronic diseases which affect the majority of the aged. This requires strategies to ensure the availability and efficiency of services such as nutrition for the young, and hypertension screening.

Again we need your assistance in providing these services.

II. Quantity of Service, for which public actions are intended to ensure the availability of, and continue the cost of services to, the population. Some of the major areas in which these actions have centered are:

A. Medicaid — While I would like to think that the Medicaid program has contributed to increased quality



Michigan House Speaker Bobby Crim confers with a fellow representative on the Governor's superagency health legislation. The accompanying article urges that physicians advise their legislators in such policy decisions.

of medical services to the poor (and I am sure that it has in individual cases) our researchers tell us that there is little evidence to support any claim of overall improved health status of the very poor over the last 10 years. It is clear, however, that the program has contributed to increased quantity of services both by private physicians, institutions, and ancillary medical professions. During the period from 1970-71 through 1974-75, total appropriations for Title XIX in Michigan exceeded $2.1 billion ($330 million directly to physicians). In spite of the proportions we know that while some providers take advantage, the majority are probably underpaid. It is also clear that by and large, decisions concerning Title XIX policy have been as reflective of ancillary political concerns as of medical concerns.

For instance: (1) The establishment of rates for nursing homes has been more the result of negotiations with the owners' association, than consensus regarding the level of services which the state needed and was willing to buy; (2) we have yet to be able to critically assess whether a patient needs a particular level of care or could more appropriately use an alternative service. We won't do this until we get the opportunity of the experience of the medical profession to give us a salable and salient view.

B. Similarly, the decision to cut $30 million from Title XIX budget by reducing payments and eliminating services is candidly aimed more at balancing the budget than predicting the impact of these changes on the behavior of provider and consumer, and thus services.

C. Certificate of Need — It was controversial when passed and it is still controversial. Osteopathic physicians, for example, are currently seeking separate certificates through an amendment to the legislation. In community after community, the certificate of need process fails because of local political pressure. If the basic intent of the legislation to reduce duplication of facilities and as a result reduce costs, has merit, then it is incumbent upon those of you in the private sector to join with us in the public sector to place some reason in local debates regarding certificate of need decisions, so they may be based on objective data. Physicians need to get more involved so that decisions are clear, and based on the most objective possible data.

III. Professional Concerns

A. Malpractice — During the first six months of this year, as a result of bipartisan cooperation between the legislature and the governor, 15 separate statutes were enacted to deal with the multifaceted problem of malpractice. These acts were achieved due to the active involvement of professional associations such as MSMS and the Bar. While they did not solve the malpractice problem, they do represent probably the most comprehensive legislative package in the country.

These and other sections are examples of legitimate involvement of government. They do, however, represent decisions that frequently are made without all available data.

What is the role of medicine? MSMS, the Department of Public Health, and Office of Health and Medical Affairs in the Department of Mental Health could be more effective and provide professional aid to the Governor and legislature. We must recognize, however, that while both public and private lobbyists are creditable they also represent organizations. Individual practitioners need to take advantage of their creditable position in the community and buttress their contacts. They occupy a unique position of influence in the community through participation on boards and the prestige of their practice.

We need a pattern of consistent informal exchange with legislators and public officers, and not only during crises.

During the coming years, federal and state government action in medicine will increase because of policies advocating deinstitutionalization and National Health Insurance. Clearly, we need a better balance between the needs of providers and consumers, and future policies reflecting good professional judgment.

The issue is that the legislators and government need to know views of practitioners. The best way to lobby is to get to know your legislator and communicate your concerns so he feels confident in the information you give him. While we all recognize compromise is often the name of the game in the political decision-making process, too often, as now in Medicaid, critical issues are resolved without basic policy first being developed.

State Bar Association Thanks MDs For Cooperation on Single Business Tax

To the editor,

Now that the Single Business Tax finally has been adopted and the dust is beginning to settle in terms of our members' understanding of the impact of this new tax on their professional activities, it seems to be an appropriate time to comment on the results of our cooperative legislative activity.

The Board of Commissioners of the State Bar of Michigan has authorized me to thank all those professional organizations which united to obtain some relief for our members from the harsh tax increase which would have resulted from this tax act as originally written. While we understand that the overall annual tax payments by almost all professionals will be larger under the Single Business Tax than under the existing tax structure, we are nevertheless pleased that, in computing their Single Business Tax, our members now have the option [under § 31 (2)] to compute their tax by reference to 50% of their gross receipts, rather than by reference to their generally larger "adjusted tax base."

This particular relief option is clearly the direct result of the concerted and cooperative joint efforts of our respective professional organizations, through their officers, volunteer members and/or legislative agents.

While somewhat less directly related to our united efforts, we are also pleased that our members who conduct their practice as proprietorships, partnerships or Sub-Chapter S corporations, will also be entitled to a modest credit against their individual income tax for a percentage of the Single Business Tax incurred in their practice. This credit relief approach was perceived by the proponents of the Single Business Tax as the sole relief provision and, the fact that it remains as an alternative relief provision, although somewhat fortuitous, is gratifying.

Beyond officially thanking you for having joined in achieving this mutually beneficial goal, we have three other purposes in writing.

First, we suspect that there are some professional organizations which are not fully aware of the efforts, and the results of those efforts, which individual officers, members or legislative agents undertook. We trust this communication will serve to stimulate proper internal credit for these individual sacrifices and accomplishments.

Second, we should all be mindful that we have received favorable consideration by the Michigan Department of Management and Budget, the Governor's office and a variety of individual State legislators, all culminating in beneficial treatment by the Michigan House of Representatives and the Michigan Senate. Since professionals are often heard to say that they are the forgotten race in having their interests considered by State government, it is particularly important that our continued appreciation and support be communicated to those of our new friends who have listened to our plight and have responded.

Third, it is perhaps most significant that, in this common cause, there has been united a number of professional groups whose interests, concerns and needs are widely divergent and, frankly, which sometimes clash. It is our sincere expectation that, at those future times when the interests of our members again cross paths, we will similarly sit down together, determine a common and mutually beneficial course of action, and cooperatively implement the same.

With the most sincere appreciation of the attorneys of this State, the State Bar of Michigan gratefully thanks each of our professional brethren who so kindly and effectively joined together in this matter.

Cordially,

Michael Franck
Executive Director
State Bar of Michigan

Scientific Meeting Session Lively

To MSMS,

Thank you for the opportunity to participate in the 1976 Annual Scientific Meeting on Current Antibiotic Usage on Wednesday, November 12th. We had a very good turn-out in our session, and it was a lively session with numerous questions from the audience. We were pleased that we had this opportunity to participate in the annual meeting.

Sincerely yours,

E. L. Quinn, MD
Henry Ford Hospital
Detroit

Thank You To MSMS For Legislative Aid

Ernest P. Griffin, M.D.
Michigan State Medical Society
120 West Saginaw St.
East Lansing, Michigan 48823

Dear Dr. Griffin:

Although it is not my usual procedure to respond to thank you letters, your recent letter (thanking legislators for their efforts in passing the malpractice bills) was greatly appreciated and I feel the need to make your organization aware of my feelings on one point.

Good legislation is based on good input, and the assistance of the Michigan State Medical Society was invaluable in our first steps towards resolving the professional liability problem. I am confident that if we continue to combine our abilities, we can look forward to further progress in the future legislative sessions.

Sincerely,

Patrick H. McCollough
State Senator

An Update On the Inteflex Introductory Course

To the editor:

I was pleased to see our article in the August issue of Michigan Medicine. Several people have raised the question – what has happened to the course since that first year? The enclosed letter, which is for publication in the journal as a letter to the Editor, will answer that question and also give recognition to the Cooperative Michigan Primary Care Preceptorship Program for their assistance.

Our article, "Introduction to Patient Care — A course for First-Year University of Michigan, Inteflex Students" which was published in the August issue of "*Michigan Medicine*," described the first year's experience with the Introduction to Patient Care course in the University of Michigan Integrated Premedical-Medical Program. Since then we have given this course two more times and this further experience has reinforced the findings and impressions described in that article. The course continues to be well received by students, faculty, and preceptors alike. In addition, we now have had the opportunity to observe this initial class through two more years of the program. A majority of the students continue to refer to it as a high point in their educational experience and they and the faculty believe it has had a positive influence on their approach to the rest of their education and on their decisions regarding career goals.

We would like to take this opportunity to acknowledge and express our appreciation for the assistance we have had from the Cooperative Michigan Primary Care Preceptorship Program. The preceptors who participated in this course were matched with our students through this program which is a joint effort of the University of Michigan, Wayne State University and Michigan State University; with the cooperation of the Michigan Academy of Family Physicians, The American College of Physicians, and the Michigan Chapter, American Academy of Pediatrics. The course could not have enjoyed the success it has had without the help of this preceptorship program.

Sincerely,

Robert E. Reed, MD
Associate Professor of Internal Medicine
Director of the Inteflex Program

Robert D. Johnson, MD
Professor of Internal Medicine
Introduction to Patient Care Course Director

Monthly Surveillance Report

Cases of Certain Diseases Reported to the Michigan Department of Public Health

For The Five-Week Period Ending Jan. 2, 1976

	1975 This 5-Week Period	1974 Same 4-Week Period	1975 Total To Above Date	1974 Total Same Date	Total Cases for 1974
Rubella	123	43	1,714	1,388	1,388
Cong. Rubella Syndrome	0	1	1	1	1
Measles	91	145	3,253	2,365	2,365
Whooping Cough	10	13	98	104	104
Diphtheria	0	0	1	0	0
Mumps	1,016	956	9,979	7,230	7,230
Scarlet Fever & Strep Sore Throat	2,846	2,071	23,777	31,802	31,802
Tetanus	0	2	0	6	6
Poliomyelitis (paralytic)	0	1	0	2	2
Hepatitis	265	203	2,877	3,599	3,599
Salmonellosis (other than S. typhi)	68	72	864	1,001	1,001
Typhoid Fever (S. typhi)	1	0	10	11	11
Shigellosis	62	113	745	1,436	1,436
Aseptic Meningitis	19	13	280	162	162
Encephalitis	27	3	168	69	69
Meningococcic Meningitis	4	6	76	54	54
H. Influenza Meningitis	22	10	142	121	121
Tuberculosis	115	73	1,220	1,094	1,094*
Syphilis	100	160	1,614	2,659	2,659
Gonorrhea	2,731	2,418	32,472	32,152	32,152

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

*Corrected total.

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cardiac palpitation and CNS stimulation. Po
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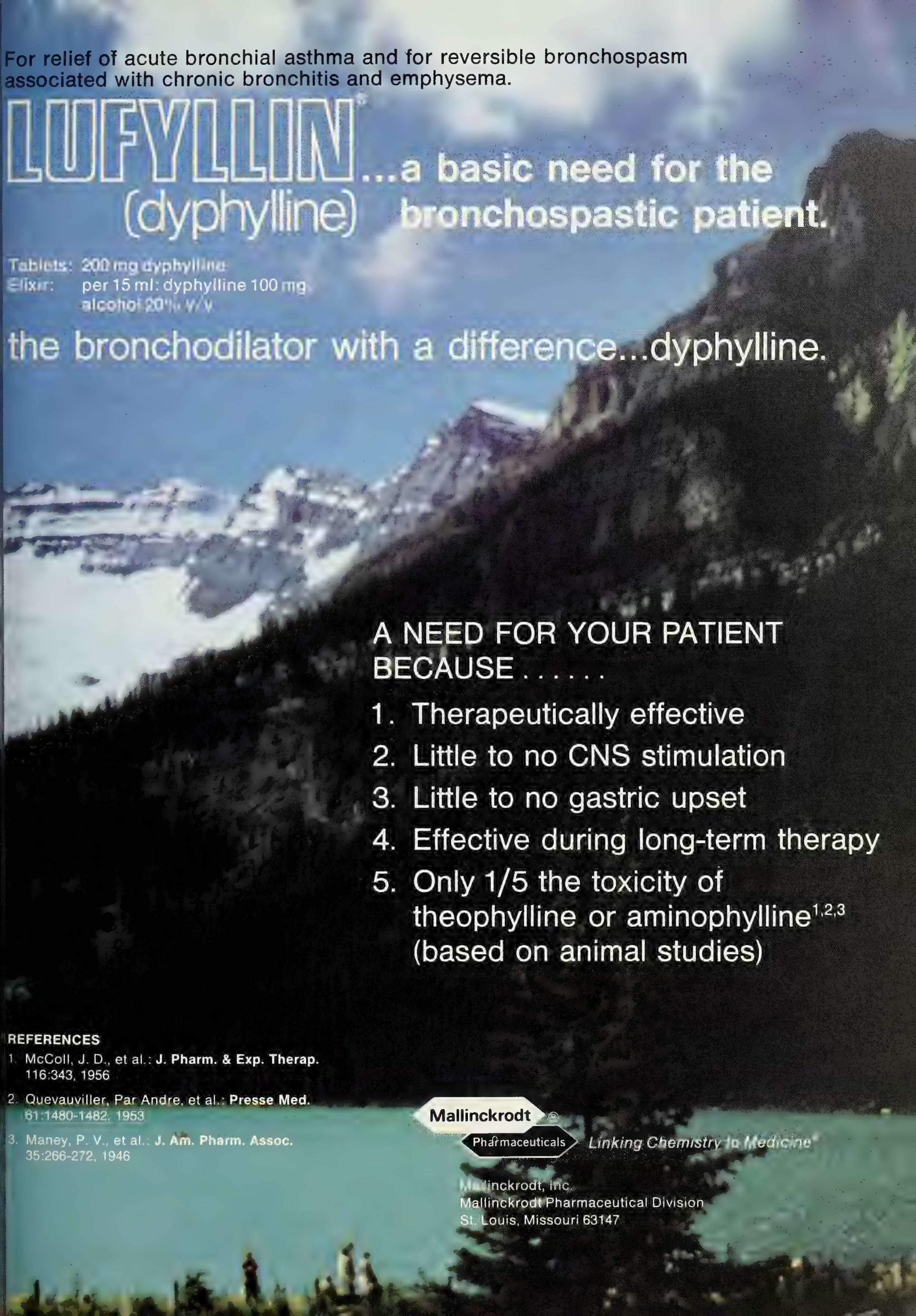
LUFYLLIN Injection: NDC 19-R537-T2, box of
X 2 ml. ampuls.



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1. McColl, J. D., et al.: **J. Pharm. & Exp. Therap.** 116:343, 1956
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commentary

Observations by a Doctor Who's Been a CCU Patient

By James A. Abbott, MD
Allen Park

On July 20, 1973 I had a myocardial infarction. Following this I was hospitalized for 22 days in a large Detroit hospital which is part of the Wayne State University Medical School complex. I was in the coronary care unit during the first six days and during the remaining period I was in the intermediate care unit.

During my hospital stay and during the time that has followed, I have had a chance to reflect on my experiences. I would like to discuss these observations, particularly as they apply to the psychology of the patient in the coronary care unit.

Let us start with the circumstances that surround the patient's admission to the hospital. A person can approach a serious operation with a certain degree of emotional preparation. He can gear himself up to it. In other sudden and severe medical conditions there are usually prodromal symptoms that enable the person to become accustomed to the idea of being sick. But a heart attack is a sudden, unplanned and unexpected event. One moment the person is pursuing his daily activities and an hour later he is being wheeled into the coronary care unit. When he arrives at the unit and has been "hooked up" to the monitor, he is told that he must be more or less completely passive.

We have, therefore, a situation in which a person, who is often a vigorous and active person, is suddenly and unexpectedly thrust into a strange world in which his life is in some danger and in which, to enhance his chances for survival, he must be as passive as possible.

In our culture, most self-sufficient adults look upon passivity as a weakness, a reminder of childhood. In addition, perhaps without realizing it fully, some people regard a passive role as a dangerous one, exposing the person to rejection and to an inability to cope with the aggressions of others. Particularly if the patient has a strong unconscious wish to be passive in the first place, will he find the stress of the passive position in the coronary care unit a difficult one to deal with.

From the reading that I have done, I do not think that this factor has been given sufficient attention or even recognition. Most articles stress the anxiety arising from the fear of dying. This is, of course, a factor. But it seems to me that a person is going to be confronted more relentlessly by his feelings about being passive (because of the necessary routine of the coronary care unit) than by his fear of dying.

It goes without saying that the benefits of the coronary care unit are so unequivocal that, except for psychosis, any disturbance of the patient's emotional state is distinctly of secondary importance. Nevertheless, I here offer a few thoughts on alleviating the strain of this particular emotional stress.

1. It would be beneficial to mention to the patient at the beginning that the demands of his passive situation are *temporary* and that in a few days he will start to resume gradually more normal activities.

2. It seems to me that allowing a patient to have as many choices in as many areas as possible would help to neutralize, to some extent, his feelings about having nothing to say about his activities. An example that comes to mind is choosing the menu for the day from two or more choices for each item.

3. I feel that having a clock and calendar in view helps to give the patient a feeling of being "on top" of things, of participating in events.

4. My personal opinion is that being able to turn one's head and look at the monitor helps in the same way, although I can imagine some patients being made uneasy by all the gadgetry.

5. It hardly needs mentioning that, having impressed on the patient the importance of being passive, it would place an intolerable burden on him if his efforts to cooperate by being passive were met with impatience or annoyance.

6. When the time comes to "unhook" the patient from the monitor and move him to the intermediate care unit, this can cause, without any pun being intended, a separation anxiety. I think that this situation can best be handled by adequate preparation for the move, by reassurance and perhaps by a little more attention by the nurses of the intermediate care unit than is physically warranted for the first half day or so.

One thing that impressed me a great deal was the autonomy of the nurses on the coronary care and intermediate care units. The new attitudes and responsibilities of nurses were undreamt of during my internship of nearly 30 years ago. They are absolutely essential for the proper running of the coronary care unit and the intermediate care unit and they represent real progress.

In summary, the coronary care unit is a relatively recent innovation in cardiology and it represents a most valuable weapon against the ravages of cardiovascular disease. In order to utilize it to its utmost potential, it is important to recognize and study the various psychological implications inherent in its use.

(Doctor Abbott is a psychiatrist with The Mental Health Clinic at the Allen Park VA Hospital.)

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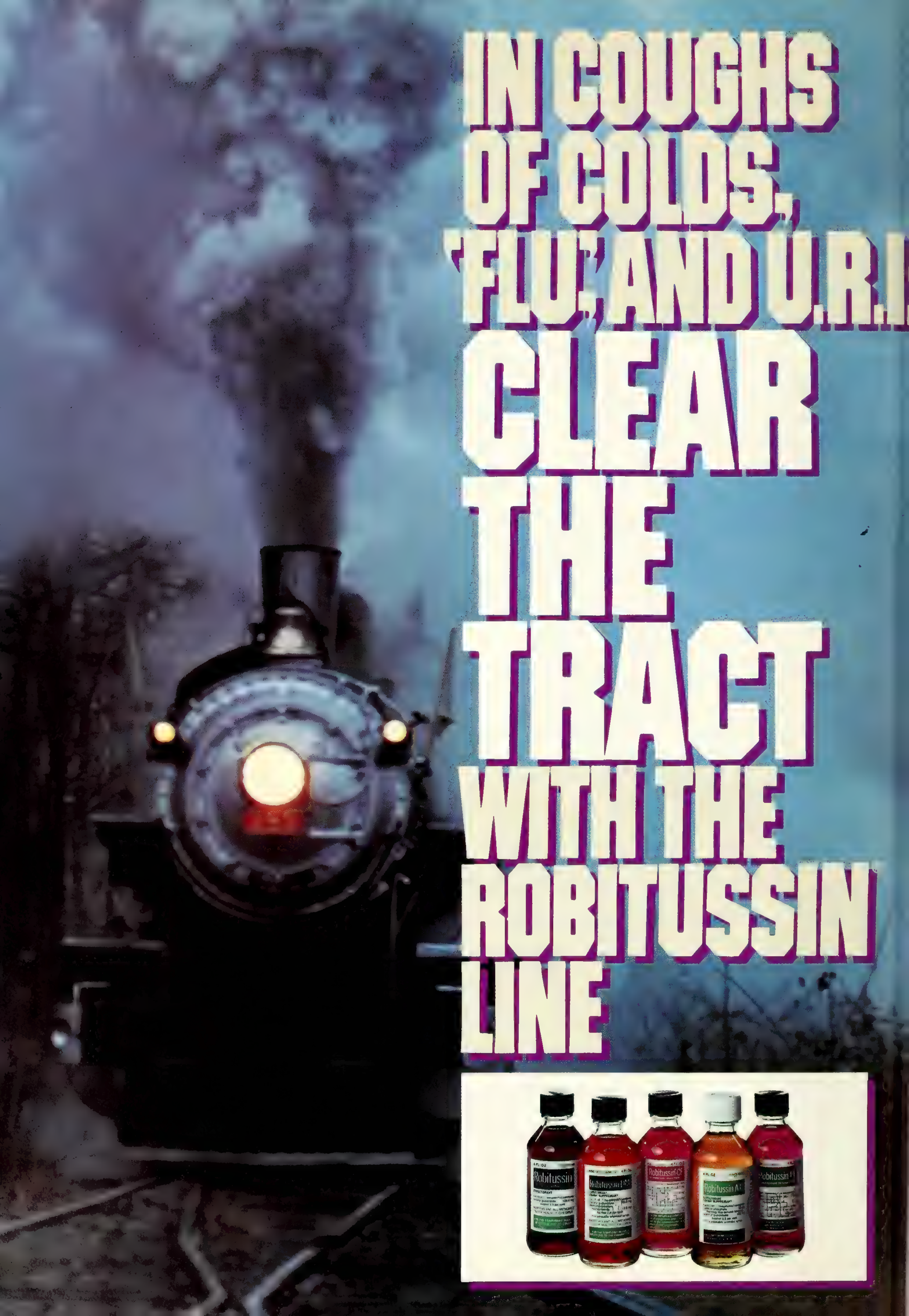
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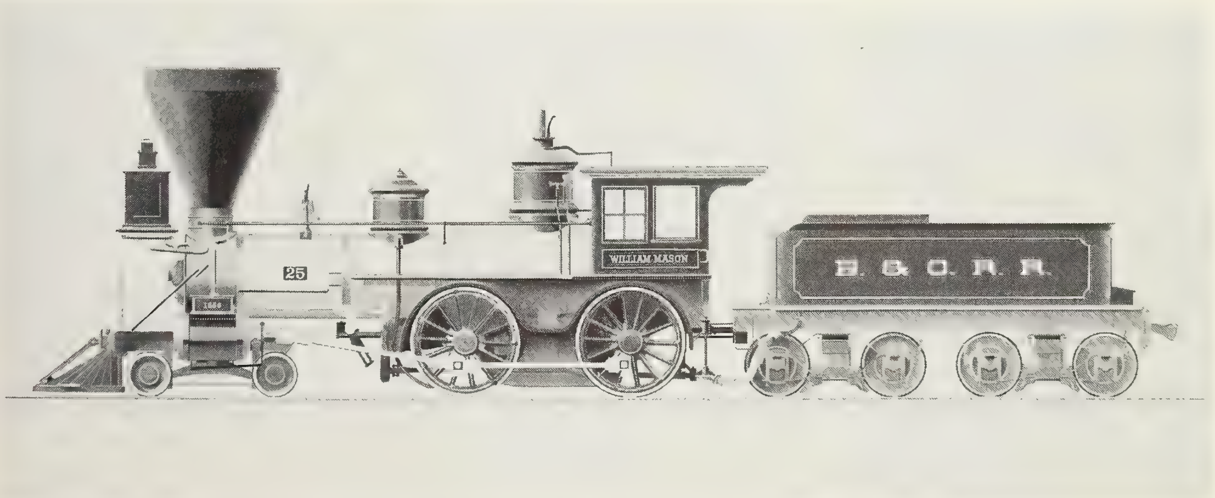

The William Mason (1856)

Michigan Psychiatric Society: "psychiatric clinics" must be defined

By Norman Rosenzweig, MD
President, Michigan Psychiatric Society

(The following article is reprinted, with permission, from the November-December issue of the Newsletter of the Michigan Psychiatric Society.)

The mail that I have been receiving from some MPS members and from other professional groups reflects considerable misunderstanding and misinterpretation of the position of the Michigan Psychiatric Society regarding so-called "psychiatric clinics."

There are some who feel that, because such clinics utilize an interdisciplinary staff, the responsibility for the operation and patient care rendered at these clinics should likewise be interdisciplinary. The position of the Michigan Psychiatric Society is the same as that of the Michigan State Medical Society and, in particular, of the Michigan Medical Practice Act, and does not represent some idiosyncratic notion of our own.

Psychiatry is not an interdisciplinary profession. It is a branch of medicine, and as such its practice is governed by the Michigan Medical Practice Act. This law requires that physicians assume responsibility for patient care, responsibility which cannot be delegated. The act defines permitting one's name or one's certificate of registration to be used by a person, group or corporation, when the doctor of medicine is not actually in charge of or responsible for the treatment given, as "unprofessional and dishonest conduct." "Unprofessional and dishonest conduct" is a cause for revocation of medical licensure.

The recent policy of the Blue Cross-Blue Shield organization which defines very loosely "psychiatric clinics" for the purpose of third party reimbursement has given rise to all sorts of abuse. While these abuses have been participated in by members of several disciplines, our own concern is strictly with members of the psychiatric profession. Our position has been to caution our membership that they may be in violation of the Medical Practice Act and hence subject to accusations of unethical conduct and even possibly to loss of licensure.

We believe that the looseness of the Blue Cross-Blue Shield definition of "psychiatric clinics," which is responsible for these widespread abuses, should be corrected. We believe this calls for a system of accountability and standards review. Blue Cross-Blue Shield requires a facility which provides inpatient services to be accredited by the JCAH in order to be eligible for Blue Cross reimbursement. We feel the same requirement should hold for outpatient facilities. Again, our motive is to put our own house in order.

At no time have we taken a position regarding the prerogatives or responsibilities of any other professional group. These are already defined by law. We have been pleased to note, however, that a group of clinical psychologists, as well as another group of clinical social workers have, on their own initiative, developed plans to institute PSRO procedures covering their own membership. We applaud all efforts by psychiatrists as well as by other mental health professionals to develop procedures for the highest possible standards of quality of care.

The Michigan Psychiatric Society has likewise been concerned with the overall problems of funding of mental health care. In the past, the practice of third party carriers was to treat psychiatric services in a discriminatory fashion, different from other medical services. Proposed national health insurance programs have tended to approach coverage for treatment of mental illness in a similar discriminatory fashion. We are most interested in assuring that funds intended to provide medical services to mentally ill individuals not be diverted to other purposes, thereby giving the false impression that health care for the mentally ill is unreasonably expensive in comparison to health care for physical illnesses. We invite inquiries and comments regarding these issues.

Please use "DAW" while you still can

By Louis R. Zako, MD Chairman, MSMS Legislative Policy Committee

Nearly a year ago, Michigan pharmacists were given the legal authority to substitute generically equivalent drugs. You will notice I said "generically equivalent," not *therapeutically* equivalent drugs. There is, as you know, a difference.

Michigan's highly touted generic drug law allows pharmacists to substitute following a request by a patient. While the law was passed with the object of saving money for the patient, the law permits the substitute generic to cost as much as the drug product it replaces. This is a curious conflict with the basic premise of the law.

As this law was moving through the Legislature in Lansing, the Michigan State Medical Society steadfastly fought for the physician's right to continue prescribing the drug products of his choice. The result of this effort is our prerogative to write "dispense as written" or "DAW" on prescriptions to prevent substitution by pharmacists.

There are a number of reasons why each of us must seriously consider "DAW" each time we write a prescription:

1. *Bioequivalence.* All generic equivalents are not equal in their actions. Some are subpotent, some are super-potent, and the effects of generics may vary from one production batch to another. Inequivalence has been demonstrated with drugs like digoxin, dicumarol, chloramphenicol, diphenylhydantoin . . . to cite just a few.
2. *Savings.* The much-heralded economic benefits for the consumer have not been realized with the law in actual practice. The consumer organizations that predicted huge savings have had to eat their words.
3. *Liability.* Writing in *Private Practice,* Morris said: " . . . the physician who prescribes by generic name, rather than by brand name, thereby increases his medical malpractice exposure unless he undertakes the additional burden of (1) informing himself of all the contents of all medical literature concerning drugs that a pharmacist may properly choose to fill the generic prescription, and (2) taking from the patient, prior to therapy, an informed consent based upon disclosure of *all* risks reported in *all* such literature for *all* such generic equivalents."

In Michigan, our control over the practice of medicine is being diluted, one step at a time. Little by little, our prerogatives are being taken from our hands.

But, while this is being done (solely for political gain), we still have an obligation to our patients. Today, in Michigan, this obligation must embrace the use of "DAW" on our prescriptions. To omit this important notation is to ignore the best interests of our patients. It is also foolhardy with respect to our own professional interests.

In Michigan, we are prescribing essentially by generic name only when we do not use "DAW."

(One of the main reasons that Doctor Zako says above, "In Michigan, our control over the practice of medicine is being diluted, one step at a time," is Michigan's HB 5325, now in the hands of the Senate Agriculture and Consumer Affairs Committee. The bill, subject of the December President's Page article in Michigan Medicine, *has passed the House.*

It would give pharmacists the power to make a generic substitution without the prior consent and knowledge of patients. And, if patients request the substitution, pharmacists must make it, in contrast to the optional system now in existence.

"This bill and the present generic drug law are poor substitutes for the quality of health care our patients deserve," comments Doctor Zako. "But we can maintain some control by writing "DAW" on prescriptions, while we talk with legislators and attempt to defeat the new, more threatening lesiglation.")

Real costs due to unneeded hospitalization

By Joel Hamburger, MD Southfield

(Reprinted from the November Bulletin of the Oakland County Medical Society)

Many hospital beds are occupied by patients who could as well be treated as outpatients. Our present method of utilization review still depends upon the willingness of one physician to "ring the bell" on his friend or associate, who next month will be in a position to "ring the bell" on him. This just will not work. There are powerful social and economic pressures which lead to continued hospitalization in acute facilities of many chronically ill patients whose survival depends upon a level of nursing care not readily available in nursing homes, even though the full capabilities of an acute facility are not needed. In many instances, the mechanism of transferring patients from an acute to a chronic care facility or home consumes many days because of lack of cooperation from the family who appreciates that all bills are paid in the hospital whereas the care may be more costly or less convenient elsewhere. In addition it must be recognized that the problem of unnecessary surgery is far from solved.

Until the economic incentives for hospitalization are eliminated both for the patient and the physician, unnecessary hospitalization and unnecessarily prolonged hospitalization will continue, and that is where the costs of medical care are highest.

MEETINGS

Feb. 10-17 – Medical Specialty Review Seminar, Snowmass-at-Aspen, sponsored by Leonard Wolin, MD, contact: Doctor Wolin, 2216 Medford Road, Ann Arbor 48104

Feb. 14 – February seminar, Michigan Society of Pathologists, Henry Ford Hospital, contact: Jacob E. Briski, MD, Department of Pathology, St. John Hospital, Detroit 48236

Feb. 19 – February meeting, "Genetic Aspects of Autoimmune Disease," Michigan Allergy Society, at Mercy College of Detroit, contact: B. David Wilson, MD, secretary, MAS, 4615 W. Main St., Kalamazoo 49007.

Feb. 26 – 1976 Special Lecture Series on Health Topics, with William Carlyon, PhD, assistant director, health education, AMA; at Central Michigan University, 3 p.m., University Center, contact: Charles E. Reed, Central Michigan University, Department of Health Education, Mt. Pleasant 48858

Feb. 27-29 – Winter Meeting, "Prevention in Psychiatry: Do You Have To Get Worse Before You Get Better?" sponsored by Michigan Psychiatric Society, Hyatt Regency Hotel, Dearborn, contact: Helen Schulte, MSMS Headquarters

March 10 – MSMS Council, at MSMS headquarters, contact: Warren F. Tryloff

March 24 – MSMS Auxiliary Legislative Day, at Olds Plaza, Lansing, contact: Jackie VanDeventer, MSMS Headquarters

March 24 – March meeting, "Insulin Allergy," Michigan Allergy Society, at The Lion's Den, Lansing, contact: B. David Wilson, MD, MAS secretary, 4615 W. Main St., Kalamazoo 49007

March 24-25 – 15th Annual Michigan Conference on Maternal and Perinatal Health at Kalamazoo Center Inn, Kalamazoo, contact: Helen Schulte, MSMS Headquarters

March 31 – Symposium — "Rheumatology for the Clinician," sponsored by Borgess Hospital, Michigan Arthritis Foundation and SW Michigan Health Area Health Education Center, at Kellogg Center, Kalamazoo, contact: Dr. H. R. Mena, 1521 Gull Road, Kalamazoo 49002

April 1 – 1976 Michigan Conference on Medical Aspects of Organized Athletics, at Long's Convention Center, Lansing, contact: Helen Schulte, MSMS Headquarters

April 5 – Annual Beaumont Lecture by Dwight E. Harkan, MD, Boston, "The American Doctor During Two Centuries," at Wayne County Medical Society, Detroit, contact: Roger Mecum, Wayne County Medical Society, 1010 Antietam, Detroit 48207

April 8-10 – Conference on Otolaryngology, sponsored by MSU Department of Surgery, Division of Otolaryngology, at Kellogg Center, East Lansing, contact: Ann E. Tsiminakis, 24 Kellogg Center, MSU, East Lansing 48824.

April 11-12 – AMA-AMPAC Public Affairs Workshop, Shoreham Hotel, Washington, D.C., contact: John Richards, MSMS Headquarters

April 12 – Annual MDPAC Congressional Reception, Capitol Hill Club, Washington, D.C., contact: John Richards, MSMS Headquarters

April 26-30 – AMA Seminar on Negotiations, at Hillsdale College, (Fee: $750, including room and board), contact: Department of Negotiations, AMA, 535 N. Dearborn, Chicago 60610

April 29-May 1 – Critical Care Symposium at Wayne County Medical Society headquarters, 1010 Antietam, Detroit, contact: Don Burkholder, WSU University Relations-School of Medicine, 540 E. Canfield, Detroit 48201

April 30-May 2 – MSMS House of Delegates, Troy Hilton, contact: Richard Campau, MSMS Headquarters

April 30-May 2 – The Council, Troy Hilton, contact: Warren Tryloff, director, MSMS Headquarters

May 12-14 – Joint Michigan/Ontario Chapter Meeting, American College of Emergency Physicians, at Four Seasons Hotel, Toronto, Ontario, Canada, contact: ACEP, 241 East Saginaw, East Lansing 48823

May 14-16 – Central States Meeting, Michigan Dermatological Society at Hyatt Regency, Dearborn, contact: James D. Stroud, MD, 15901 W. Nine Mile Rd., Southfield 48075

May 19 – Annual Meeting, Michigan Allergy Society, contact: B. David Wilson, MD, secretary, MAS, 4615 W. Main St., Kalamazoo 49007

May 19 – 108th Annual WSU Medical Alumni Reunion Day, Michigan Inn, Southfield, contact: Don Burkholder, PhD, WSU University Relations-School of Medicine, 540 E. Canfield, Detroit 48201

May 27-28 – Committee Meeting on Maternal and Perinatal Health at Gull Lake MSU Conference Center, contact: Helen Schulte, MSMS Headquarters

June 2-4 – Annual meeting, Michigan Public Health Association, Grand Hotel, Mackinac Island, contact: LaRue Miller, executive director, MPHA, 403 Seymour, Lansing

June 21-25 – 12th Annual Northern Michigan Summer Conference, sponsored by U-M Department of Post Graduate Medicine and Health Professions Education, at Shanty Creek Lodge, Bellaire*

June 26-July 1 – AMA Annual Convention, Dallas

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*Contact: Robert K. Richards, PhD, director, Office of Intramural Education, Room 6-1109, Towsley Center for Continuing Medical Education, University of Michigan Medical Center, Ann Arbor 48104.

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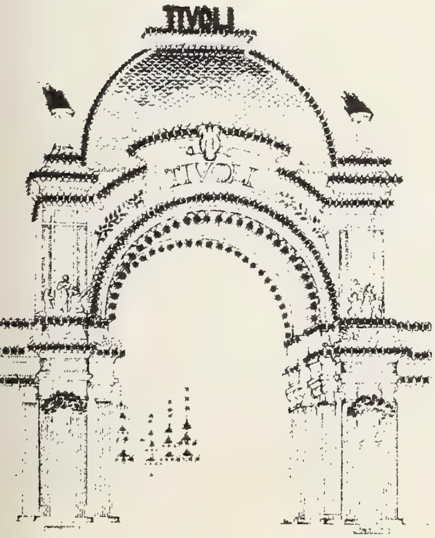

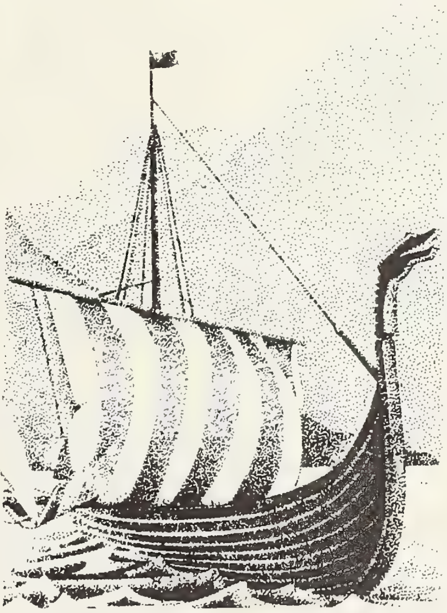

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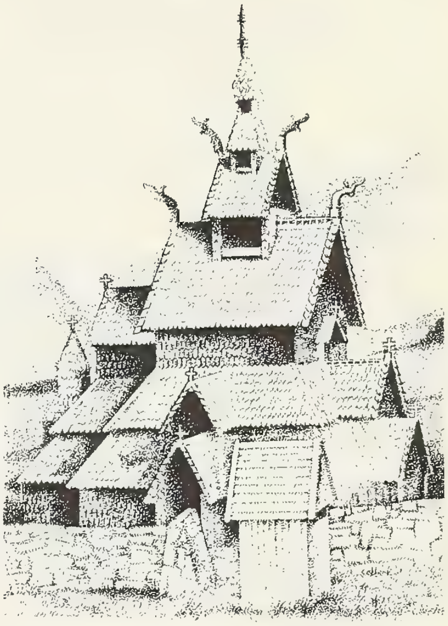

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1976: Phase II for malpractice legislation

By Thomas R. Berglund, MD, Kalamazoo
Chairman, MSMS Committee on State Legislation and Regulations

> *"We have resolved the short-term crisis in availability of insurance and laid the groundwork for the long-term solutions to the medical malpractice insurance problem . . . "*

With those words, Governor Milliken last July signed a major portion of the 16-bill legislative package on professional liability for 1975.

Now the State and Michigan physicians turn to the "long-term" solutions, and the demand for legislative action is no less than it was a year ago.

While the voluntary, binding arbitration program is being implemented, and both the State and MSMS move into professional liability insurance programs, continued work is necessary on the legislative front. Participation by physicians with their legislators will be as important, or perhaps even more so, in 1976 as in 1975.

MSMS leadership already has turned its attention to legislation that will have permanent impact, and has established a 1976 program that includes:

(1) An attempt to define by statute what malpractice is, in contrast to bad results.

(2) Further strengthening of the Statute of Limitations.

(3) Changing the manner in which judgments can be awarded from lump sum to "annuity-type" payments, and a ceiling on payments for pain and suffering.

(4) Work with the Michigan Hospital Association toward obtaining affidavit of merit, burden of proof, and waiver of privilege legislation.

What will these objectives achieve if enacted into law?

(1) A statutory definition of malpractice could solve one of the major problems plaguing doctors in professional liability cases. That is the situation when all medical standards

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are met, yet the result is an unhappy one. Physicians have argued for years that medical maloccurence, despite the best of physicians and hospitals alike, causes more suits than anything else.

Writing such a statutory definition will be difficult, indeed. Malpractice is much more than mere negligence. Community standards of practice, variances among communities' medical equipment, availability and accessability of consultants, peer review and expanding medical knowledge, all will play a part. Because of the challenge provided by this objective, the chairman of The Council of MSMS (Ernest P. Griffin, MD, Flint) has been directed to appoint an ad hoc task force to work with legal counsel in drafting a statutory definition of medical malpractice. If and when that draft is achieved, it becomes the highest legislative priority of MSMS.

(2) Strengthening the Statute of Limitations will be a continuing goal of MSMS. Gains were made in 1975 by limiting the statute to two years for adults, plus six months upon discovery of any alleged injury which could not otherwise have been discovered in the two year period. Further refinements can be made in regards to children, and a fixed period with no "opener" provision. MSMS and the Michigan Hospital Association are striving to write mutually acceptable amendments to the statute, and approach the Legislature jointly.

(3) Changes in the manner in which judgments are paid could have major beneficial effect on financial stability of insurors. Michigan's new arbitration law already provides for a variety of types of reparations to the patient. The court system remains fixed on lump sum payments, however, and MSMS will seek amendments to permit periodic payments in lieu of single payouts. Along with that will be MSMS' long-standing argument against excessive payments for pain and suffering. MSMS officially recognizes there can be no ceiling on judgments for actual losses; indeed, one state's new statute for a ceiling already has been found unconstitutional. However, ceilings on pain and suffering awards can be legislated and, the Medical Society believes, ought to be legislated.

(4) While the necessity of affidavit of merit legislation is lessened somewhat by the institution of arbitration in Michigan, there remains strong feeling that such a statute would discourage frivolous suits against those physicians who still choose courtroom litigation. With the hospital association, MSMS hopes to develop a package bill that would amend the Judicature Act to require an affidavit of merit, place the burden of proof upon the plaintiff (a reverse approach to res ipsa loquitor) and provide for waiver of privilege when suit is filed.

With the achievements of 1976 behind, there will be more difficulty in challenging the legislature to act in 1976. The best place to organize and effect impetus to continue the statutory attack on professional liability problems is at the component society level.

We who serve on the MSMS Committee on State Legislation and Regulations hope county societies will place on their agendas the 1976 malpractice objectives, and keep their legislators attuned to our continuing needs.

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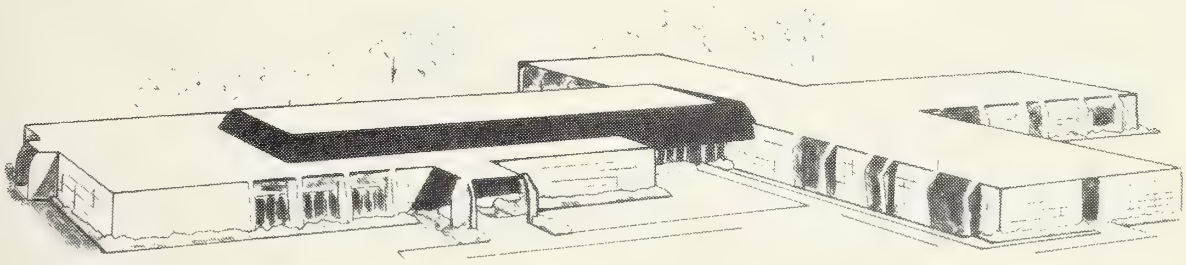

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REGIONAL C.M.E. MEETINGS

Jan. 17, 18	Tulsa, Okla.
Feb. 28, 29	Denver, Colo.
March 17-20	Lexington, Ky.
April 3, 4	Indianapolis, Ind.
April 3, 4	Detroit, Mich.
May 9	Dallas, Tex.
Sept. 4, 5	Jackson Hole, Wyo.
Sept. 11, 12	Milwaukee, Wis.
Sept. 10-12	Portsmouth, N.H.

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Principles For Better Lobbying

Pointers on effective lobbying ere offered by guest speaker ene Dyson, president, Georgia usiness and Industry Associa- on at a recent MDPAC work- hop. His remarks were so good nd to the point that they are be- g reprinted here for the many ISMS members who were unable attend the MDPAC session.

Principles for better lobbying:

(1) Reach a concensus among our members on issues, then go rth to do battle in the legisla- ve arena united — otherwise, ou'll get picked off one by one.

(2) Go to the pros — your rofessional staff members and hers with credentials — rather an relying on news media or liticians for your information nd strategy.

(3) Get to know your legisla- rs, their backgrounds, motiva- ons, intelligence, personalities, gislative records, even their osest neighbors on Senate and ouse floors, who can have a ma- r influence on how they vote.

(4) Meet and get to know all ew members of the legislature.

(5) Get your friends regis- red to vote, particularly those ho feel as you do on vital is- ues.

(6) Know the two major rules politics — namely, that politi- ans must get re-elected, and at "politics is the art of compro- ise."

(7) Use television, as it is the urce of most Americans' opin- ns.

(8) Describe your issues in terms of the public good and not in your own self interest. Explain your views' advantages to your constituents.

(9) Find a way to be sure that you have communicated with your legislators, to make sure that they receive your message.

(10) Adjust for new developments and prepare alternative plans for changing situations.

(11) Help the governor, as he can sponsor your legislation and veto bills you don't approve.

(12) If you are testifying, then you should know all there is to know about the committee members you are addressing: be precise and careful, and be sure your friends are present as you testify. Also be prepared for loaded questions, and don't answer, "I don't know." Instead answer "I'll get that answer for you." When testifying, give out printed copies of your remarks, so you won't be misquoted by the news media; and be prepared to meet the press after testifying and stand by your statement in testimony.

(13) Know the resources for information available to you and your legislators.

(14) Remember that lobbying is hard work, but you are living in jeopardy if you don't devote some part of your life to government.

How Things Look To the Legislator

At that same MDPAC meeting, Sen. Earl Nelson (D-Lansing) also had some pertinent remarks to make of direct impact on MSMS members. Following are some quoted at random:

"I look at government as a board of directors elected by the people, and the governor as the chairman of the board."

"Where do we get our information? That's the key. What information do we have? It's so important. We had to pass a bill to get the information we wanted on the medical malpractice issue. Doctors wouldn't say, insurance companies wouldn't say, lawyers wouldn't say. Let's don't hide information. We all want the best possible medicine that can be provided.

"The people aren't going to deny their input in what it takes to run the system. They won't be quiet any more and they will change politics.

"Legislators have to spend half their time lobbying each other, without making a deal — that's the hard part.

"MSMS has to have issues other than those directly related to the medical profession and its growth.

"The alternative to pressure group politics through lobbying is test tube politics. If you keep the people pure from influence by their backgrounds, you send test tube people to government."

COUNTY SOCIETIES

WCMS stages Bicentennial medical exhibit in Detroit

Thousands of Detroit area residents viewed the Wayne County Medical Society Bicentennial Exhibits in the main Detroit Public Library, on Woodward, from Dec. 13 to Jan. 31. The Dec. 13 date was special too — WCMS held an elaborate holiday dinner party at the Library to unveil the exhibits.

About 20 exhibits were grouped in the third floor exhibit hall and in the exhibit cases on the main floor.

The project was handled by a special WCMS Bicentennial Committee with Alfred H. Whittaker, MD, and Ned I. Chalat, MD, past president, as co-chairmen.

Some of the materials from the Beaumont Collection, always on exhibit in the WCMS headquarters, were moved to the library, and the WSU Medical School exhibit about Beaumont had a prominent first-floor location.

Other exhibits featured the Wayne State University medical school, Detroit Medical Center, Henry Ford Hospital, Harper Hospital, St. Mary's Hospital (now Detroit Memorial Hospital), Sinai Hospital, the early Detroit black hospitals, Shiffman Clinic, Rehabilitation Institute, Family Practice Residency Program at Bon Secours, and an exhibit about Crib Deaths.

There also were exhibits honoring Bertha Van Hoosen, MD, the first president of the American Medical Women's Association; Douglass Houghton, MD, mayor of Detroit in 1842 and famed state geologist; and Zina Pitcher, MD, former mayor of Detroit and the 10th president of the AMA.

Materials for the exhibits were loaned by Jack H. Hertzler, MD, H. J. Vanden Berg, MD, L. Reynolds Associates, Clara Raven, MD, Alexander Blain, III, MD, William G. McEvitt, Richard Anslow, MD, Edward Hill, MD, Ned I. Chalat, MD, Muir Clapper, MD, Charles F. Whitten, MD, and Emily Bandera, MD.

* * *

Another county medical society contributing to the public understanding of medicine is the **Kent County Society** which recently donated a human skeleton to the Grand Rapids Public Museum as part of a new permanent exhibit. While a skeleton in itself is not unusual this one is a bit out of the ordinary. It features numerous artificial joints as developed by physicians in Grand Rapids and across the world. The exhibit was donated by the Kent

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ounty Medical Foundation and the ent County Medical Society.

* * *

Muskegon County Medical So iety members and spouses enjoyed etroit *Free Press* columnist Bob albert as the speaker at their an ual society dinner meeting. Mr. albert spoke on "The Care and eeding of Communications Gap."

* * *

Popular Bud Guest, Michigan hu orist, lecturer and story teller, was e speaker for a crowd of more than 00 at the annual "President's ight" of the **Ingham County Med al Society** last month. This year's onoree was Thomas C. Payne, MD, ew Ingham president who also is ry active in several key MSMS mmittees.

* * *

The **Macomb County Medical ociety** recently received a commen ation in resolution form acknowl dging the outstanding membership the society and their contribution the Macomb Community College.

Across the Nation . . .

Pennsylvania Medical Society is very critical of a study on doctors' incomes released by the Pennsylvania Secretary of Health Leonard Bachman, MD. PMS officials complained that it was an invasion of privacy to obtain income figures from the Pennsylvania Department of Revenue. PMS officials also criticized the use of gross income figures rather than net.

* * *

The Indiana State Medical Association is undertaking a study now about the feasibility of "establishing a socio-economic division to provide data for dealing with other groups, public or private." MSMS established its Bureau of Economic Information for those same general purposes in 1970.

* * *

The Texas Medical Association, as does MSMS, encourages physicians to participate in the various regional health planning programs. The chairman of the TMA committee on health planning, Sam R. Barnes, MD, puts it this way: "We are well aware that the majority of our members view federal programs, in general, with the same opprobrium that a possum does an axe handle, but progress is being made."

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In Memoriam

Harry B. Bennett, MD
Southfield

Long-time Detroit-area physician Harry B. Bennett, MD, Southfield, died Dec. 31 at the age of 76. Doctor Bennett was retired. He had been on staffs of Grace, Sinai and Detroit General hospitals, as well as the Jewish Home for Aged. He was a member of the American Geriatric Society and was a graduate of the Detroit College of Medicine. He was the chief Detroit city physician from 1935-1945.

Roy D. Craig, MD
Birmingham

Roy Dale Craig, MD, Birmingham psychiatrist, died Dec. 29 at the age of 66. He had been affiliated with Harper and Grace hospitals and was a graduate of Wayne State University Medical School. He was a member of the American and Michigan psychiatric associations and the New York Academy of Medicine.

Howard P. Doub, MD
Detroit

Past president of the American College of Radiology, the Michigan Cancer Foundation and Southeastern Michigan Division, American Cancer Society, Howard P. Doub, MD, died Dec. 26 at the age of 85. Doctor Doub was radiologist-in-chief at Ford Hospital for more than 30 years and had been affiliated with the hospital for almost 50 years. He also was past president of the Radiology Society, editor of the *Radiology Journal* for 25 years and had received AMA awards for his work on a team researching the effect of X-rays. He was a graduate of Johns Hopkins University medical school.

Edward J. Grass, MD
Grand Rapids

Grand Rapids physician for 30 years, Edward Jacob Grass, MD, died Oct. 18 at the age of 78. Doctor Grass was affiliated with Butterworth, Blodgett and St. Mary's hospitals in Grand Rapids and served as vice president of the Kent County Medical Society. He was graduated from George Washington University medical school, where he served 10 years on the faculty. He was awarded the Legion of Merit, Oak Leaf Cluster, Bronze Star and two Purple Hearts for service in World War II. He was a member of the American Academy of Family Physicians.

William J. Hopkins, MD
Southfield

William Joseph Hopkins, MD, Southfield urologist, died Dec. 25 at the age of 60. Doctor Hopkins retired in 1971 and had been affiliated with Henry Ford and Mt. Carmel Mercy hospitals. Doctor Hopkins, a graduate of Creighton University medical school, was a member of the Detroit Urology Society and North Central Branch, American Urological Association.

John H. Kitchel, MD
Grand Haven

John H. Kitchel, MD, Grand Haven family physician since 1941, and a national conservation authority, died Dec. 20 at the age of 65. He was one of the top 10 conservationists of the nation in 1969 and Michigan United Conservation Club's Man of the Year in 1974. He was past president of the MUCC and of the National Wildlife Foundation and was an advisor to the Great Lakes Fisheries Commission. He was a graduate of Indiana University School of Medicine and was affiliated with North Ottawa Community Hospital and the Ottawa Family Planning Clinic.

Arthur M. Moll, MD
Grand Rapids

Grand Rapids otolaryngologist Arthur M. Moll, MD, died Dec. 14 at the age of 80. Doctor Moll was a graduate of the University of Pennsylvania medical school and had practiced in Grand Rapids since 1923. He was associated with the city physician's office and Butterworth, Blodgett and St. Mary's hospitals. He was a member of the American Academy of Ophthalmology and Otolaryngology.

Leland B. Phelps, MD
Bad Axe

Leland B. Phelps, MD, Bad Axe physician since 1972, died Dec. 16 at the age of 44. Doctor Phelps previously practiced in Grand Rapids and Reed City, following his graduation from Wayne State University School of Medicine. He also had been a jet pilot instructor with the U.S. Air Force.

Nathaniel Sandler, MD
Southfield

Southfield psychiatrist Nathaniel Sandler, MD, died Nov. 30 at the age of 63. Doctor Sandler had practiced in the Detroit area for 40 years following his graduation from Wayne State University School of Medicine. He was a member of the Michigan and American Psychiatric Associations. He was affiliated with Brent and Elliott general hospitals, Detroit.

John C. Stageman, MD
Clarkston

Pontiac-area surgeon and otolaryngologist John C. Stageman, MD, died Dec. 18 at the age of 69. Doctor Stageman was affiliated with St. Joseph Mercy and Pontiac General hospitals and had practiced in Pontiac since 1946. He was a graduate of the University of Iowa medical school and had practiced in Detroit.

Julius C. Tapert, MD
Detroit

Long-time Detroit family physician Julius C. Tapert, MD, died Dec. 31 at the age of 70. He was on the staff of Deaconess Hospital for 35 years until his retirement in 1965. Doctor Tapert was a graduate of the Wayne State University School of Medicine.

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NEW PROFESSIONAL BUILDING — 5001 West St. Joe, Delta Township, Lansing. Quality space available — February. Excellent location, 70% owner occupied. Still time to design your own suite. Call Collect (517) 481-5539.

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PHYSICIAN IN FAMILY PRACTICE needed to join two other physicians in Essexville, Michigan. Lovely residential office in Bay City area. Excellent medical community. Fine schools. On Saginaw Bay with good recreational features. Excellent starting salary with partnership available. Write or call: Dr. A. Moeller, M.D., 700 Borton, Essexville, Michigan 48732 (517) 894-2926.

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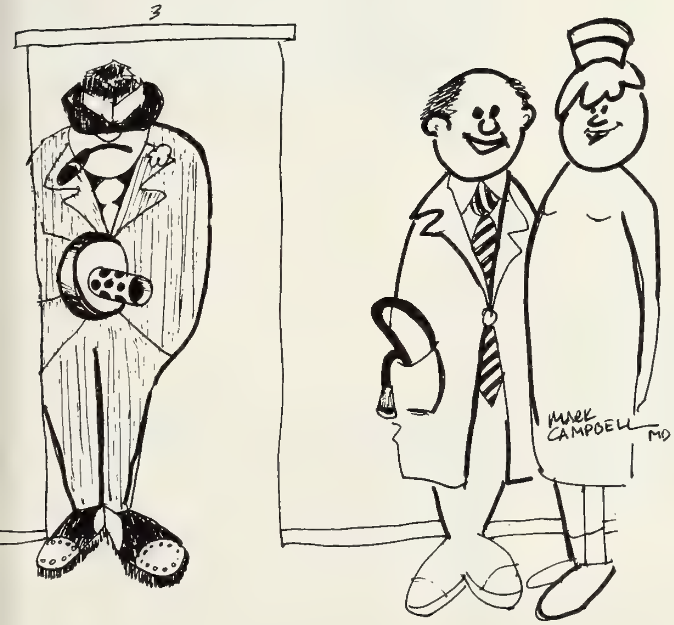

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POTPOURRI

By Herbert Auer
Executive Editor

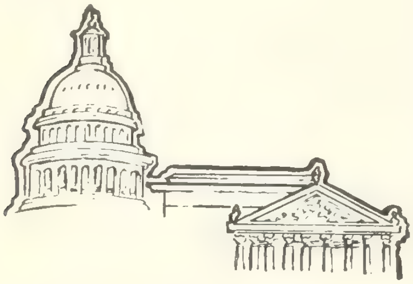
Short Quiz:
If the opposite of "Pro" is "Con,"
Then what is the opposite of "Progress"?

* * *

Recently Irvine H. Page, MD, editor, wrote in his *Modern Medicine* journal about pitchmen, whom he described as "flamboyant, theatrical salesmen whose concern for truth is undetectable." And then he commented that "Certainly one of the most interesting forms of pitchmanship is perennial in the US Congress, because it involves multiple pitchmen and the put-on is so cleverly maneuvered."

* * *

The General Accounting Office in Washington has issued a new report that in part says, "Government has wasted millions of dollars promoting experimental health care programs that are often mismanaged and ineffective."



* * *

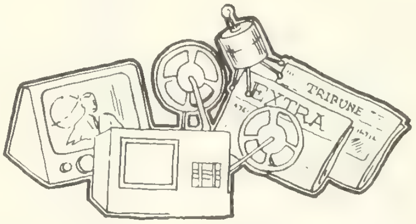
FCC is considering a ban on all over-the-counter drug advertising on television between 6 a.m. and 9 p.m. The ban was requested on a petition signed by 17 state attorney generals. Kelley of Michigan was not one of the 17. The petition bemoaned that TV ads "bombard children and adults to present drugs as a cure-all to the tensions and problems of everyday life."

* * *

The Federal Trade Commission has ordered four West Coast travel agencies to stop promoting "psychic surgery" tours to the Philippines. The Commission has called the so-called surgery, "pure fakery and a fraud."

* * *

When commenting on the FTC efforts to lift the ethical ban on physician advertising, William S. Reveno, MD, wrote in the *Detroit Medical News*, "When the ban on MD advertising is lifted, look forward to portal-to-portal service, credit card acceptance, ceiling movies, video tape of operations, perfumed anesthetics, a framed photo of the proctologist, and week-end discounts."



* * *

"The MSMS journal is an important asset of the State Medical Society, and its value to the members cannot easily be computed in dollars and cents. It offers a valuable forum in which the voice of every member may be heard." (Excerpted from Annual Address by MSMS President C. C. Clancy, MD in October, 1925 MSMS Journal)

* * *

Teachers, like doctors, get many surveys to answer. Recently a Southern Illinois University research project asked 650 high school teachers and administrators which of 13 professional journals they read most often. The second-best read journal, according to the survey was *Today's Teacher*, which was one of three fictitious titles included!

* * *

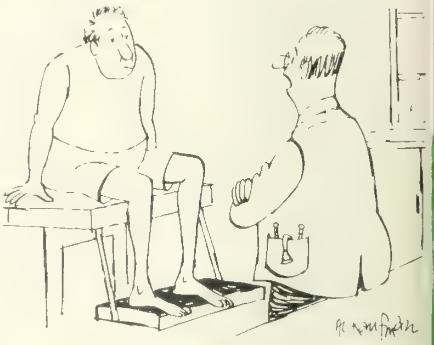
As we observe the birthday month of Abraham Lincoln, remember that he once said, "you cannot help men permanently by doing for them what they could and should do for themselves."

* * *

The Women's Hospital Unit of University of Michigan Hospital is rated "one of America's top 10 hospitals for women" by a blue ribbon panel of health care experts commissioned by the *Ladies Home Journal.*

* * *

"Editors too often assign incompetent reporters to write about the medical scene," Michael E. DeBakey, MD, president of Baylor College of Medicine, told the recent AP Managing Editors Convention. AP President Wes Gallagher urged the newsmen "to examine the price tags on NHI proposals and the possible effect on existing medical care."



"Yes, I do feel a bypass is in order. Bypass the refrigerator, bypass the cupboard, bypass the pizza parlor."

1976 MICHIGAN CONFERENCE
MEDICAL ASPECTS OF ORGANIZED ATHLETICS
Team physicians, trainers and coaches are invited to attend this MSMS-sponsored conference April 1 at Long's Convention Center, Lansing . . .
see page 130

MICHIGAN MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 3 MARCH 1976

TO FIND OUT WHAT 'MSU IS DOING IN THE UP,' read about the enthusiasm of physicians involved in the MSU Upper Peninsula training program for family physicians . . . see page 132

DEBATING INCORPORATION?
Study the pros and cons as offered by MSMS economics experts . . . see page 160

SOME OFTEN-ASKED QUESTIONS
ABOUT ARBITRATION

Check the answers here to many physicians' most frequent queries about the new arbitration system in Michigan . . . see page 161

MICHIGAN PHYSICIANS WILL BE PARTICIPATING
March 24-25 in the 15th annual Michigan Conference on Maternal and Perinatal Health, at the Kalamazoo Center Inn, Kalamazoo.

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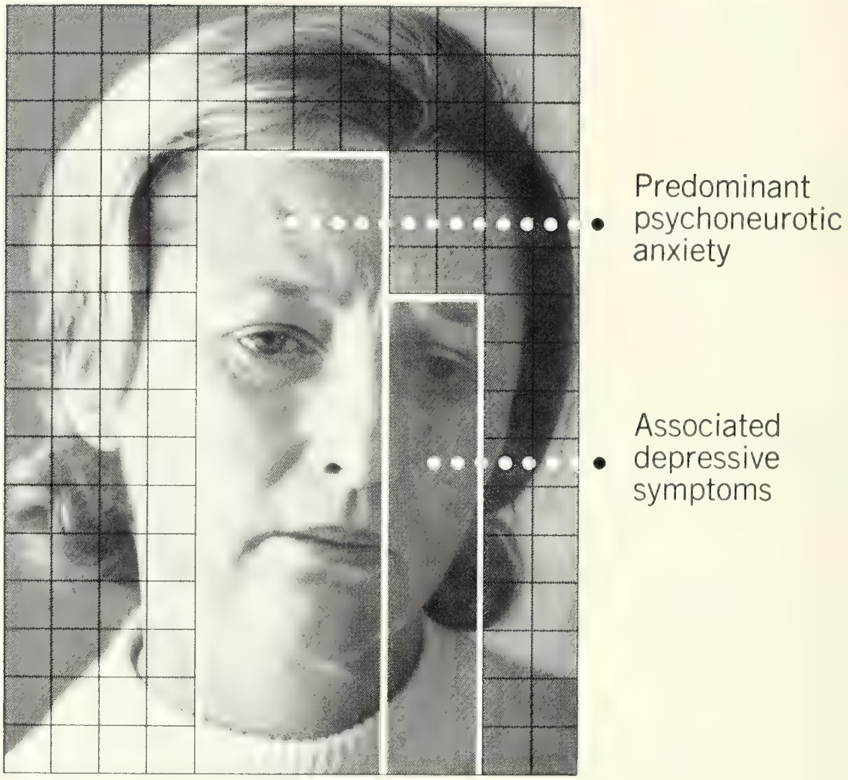
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respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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anxiety states
with associated
depressive symptoms

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the Next Issue

In the April issue of Michigan Medicine, *Michigan physicians, legislators and philosophers will debate important issues of death. The Michigan Physicians Mutual Liability Company will bring MSMS members up to date on its progress, and the highlights of the coming MSMS Annual Session will be described. Watch for them.*

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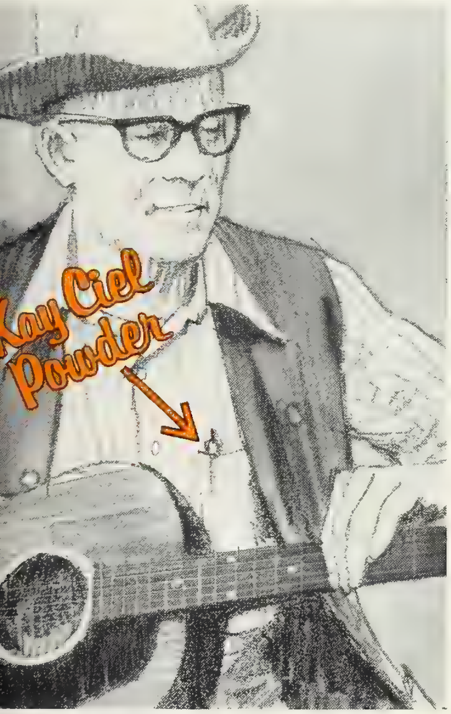
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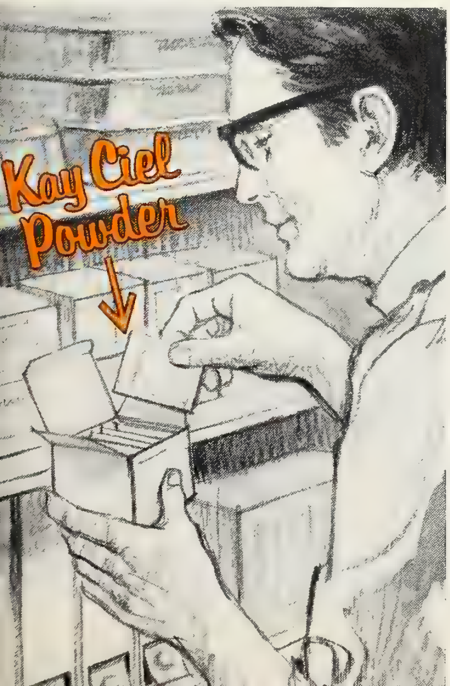
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AMA's vigor apparent at leadership meeting

Brock E. Brush, MD,
MSMS President

I was really impressed!

As your president, I participated in the AMA National Leadership Conference recently in Chicago — and was much impressed with presentations of the positive AMA programs.

About 20 MSMS and component society leaders heard major addresses and took part in workshops on medical legislation, professional liability, arbitration, continuing medical education, communications, socio-economics, and other vital topics.

HEW SECRETARY F. David Matthews told the 700 participants that he "looks forward to a continuing partnership with the AMA." Rep. Dan Rostenkowski, chairman of the House Ways and Means Committee's Subcommittee on Health, urged the AMA "to provide leadership and assistance" to his panel as it attacks health care costs.

In a workshop about national health planning, AMA Executive Vice President James H. Sammons, MD, termed the Health Planning and Resources Development Act "as the single, most potentially destructive piece of legislation ever enacted by Congress." He threatened further AMA actions in the courtroom, if the AMA cannot communicate effectively with government in the conference room. AMA President Max H. Parrott, MD, President-Elect Richard E. Palmer, MD, and Doctor Sammons all came through loud and clear that the AMA is in a militant mood.

OUR OWN JOHN J. COURY, MD, MSMS past president and member of the AMA Committee on National Legislation, was impressive as the moderator for the workshops on federal legislation. Coincidentally, MSMS members are going to work hard to convince the AMA House of Delegates in June to elect Doctor Coury to the AMA Board of Trustees.

MSMS members also were proud to watch George W. Slagle, MD, another MSMS past president and now the AMA vice president, during the AMA Board of Trustees discussion at the conference.

The new Michigan professional liability arbitration procedures were explained at the AMA workshops by Bruce Ambrose, manager, MSMS Department of Government Relations.

I was very interested in the comments at the conference by Newton N. Minow, Chicago attorney, about the FTC's complaint that the AMA's ethical ban on the solicitation of patients is in restraint of trade. The complaint, said Mr. Minow, "is an example of the clash between government's mass 'solutions' and individualistic professional values."

Once again, let me emphasize that I was impressed with the new vigor being demonstrated by the AMA as it protects the interests of the medical profession and our patients.

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Equivalent to
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KEFZOL
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Meet MSMS's newest staff member: System 32

The newest MSMS staff member is merely a number. And deals in numbers. This staff member is willing to spend hours working on tedious lists of figures with nary a complaint.

Who is this remarkable addition? None other than the new IBM System 32 Computer.

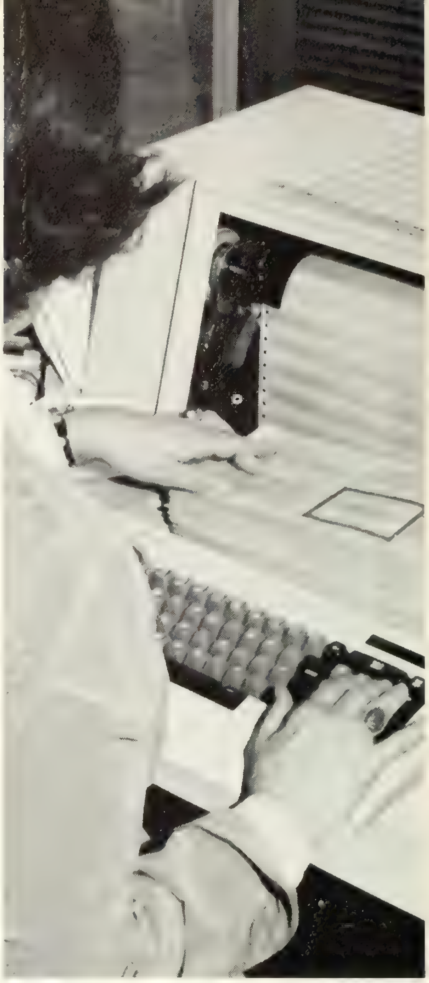
System 32 came aboard after much careful thought and deliberation by the MSMS Council and staff on improving the MSMS operation and services to members.

The computer's first duty was to prepare the 1976 membership billings.

But the major task facing System 32 is the maintenance and updating of MSMS membership records. Previously, all membership records were kept through a manual punching-card system which was run through an outside computer. Delays and errors inevitably followed.

With System 32, MSMS will be able to produce, as needed, complete data on any MSMS member, including the type of practice, location, type of residency and internship training, medical school and year of graduation.

Among the benefits to component societies will be an available printout on all physicians within a given county, indicating members and non-members. The System 32 also will enable MSMS to process important surveys faster and provide important economic data to members via *Michigan Medicine and Medigram.*



MSMS dues billings are processed by MSMS computer operator Peg Berry on the new MSMS System 32 computer.

Another function of System 32 will be to manage a host of internal accounting procedures including general ledger, payroll, accounts receivable and accounts payable.

From the general membership data stored in the computer, MSMS will be able to print all membership mailing labels bearing each member's medical education number which now assumes new importance due to the 50 hours continuing education credits necessary each year.

MSMS is exploring the possiblity of offering other services to components and specialty societies. At present MSMS is collecting membership dues for all but five MSMS components. Other available services will be announced as they are developed.

The next time you're in the building stop by and see our new employee at work.

Leaders of large component societies, led above by Robert M. Rice, MD, Greenville (back to camera) and small components, led by Thomas C. Payne, MD, Lansing, swapped ideas for better leadership, meetings and membership at a recent MSMS workshop.

The latest developments in medical legislation, continuing medical education, MSMS and state liability insurance companies and forthcoming MSMS programs were detailed for component society leaders in their recent leadership workshop at MSMS headquarters. Ernest P. Griffin, Jr., MD, Council chairman, standing left, presided during the day, assisted by MSMS staff members who included Richard Campau, center, and Warren Tryloff, right, director.

MSMS signs contract with anesthesiologists

MSMS is completing negotiations to provide administrative services to the Michigan Society of Anesthesiologists. When completed, the contract with the Anesthesiologists will be the second negotiated by MSMS with a state specialty organization. MSMS has assisted the Michigan Psychiatric Society with its administrative activities for more than two years.

The anesthesiologists' executive committee, led by MSA President D. W. Hesselschwerdt, MD, Grand Rapids, approved the final contract version with MSMS on Jan. 7 to pave the way for MSMS to handle MSA membership records, dues billings and collections, meeting arrangements and secretarial services.

The MSA requested the services arrangement of MSMS, which has designated a new Special Services Office to handle MSMS affiliations with medical assistants, MSMS Auxiliary, Michigan Psychiatric Society and any future specialty societies who contract with MSMS for administrative help.

"We are very interested in working together on projects of mutual interest," wrote Michael Cardin, left, assistant dean for health legislation and development of the U-M School of Public Health, following a recent visit to MSMS headquarters. U-M School of Public Health Dean Richard Remington, second from left, initiated the visit. MSMS was represented by Robert M. Stowe, MD, MSMS councilor, standing, and Sherry Wellman, MSMS staff liaison with governmental agencies, right.

10th annual program for team doctors, trainers and coaches . . .

1976 CONFERENCE ON MEDICAL ASPECTS OF ORGANIZED ATHLETICS
THURSDAY, APRIL 1, 1976
LONG'S CONVENTION CENTER, LANSING (I-96 & Cedar Exit)

Sponsored by Michigan State Medical Society

8:00 Registration Desk Opens

9:00 Morning Program:

Subject: "Evaluation of the Upper Extremity in the Athlete"
- H. Royer Collins, MD, orthopedic surgeon, Cleveland

"Medical Fads in Athletics"
- Tom Johnson, MD, MSU College of Human Medicine

"The Woman Athlete — Is There a Difference?"
- Nel Jackson, PhD, Assistant Athletic Director for Women's Sports, Michigan State University

"Ask the Trainers" (A Question and Answer Panel Program)
- Kenneth Kopke, Head Trainer, Central Michigan University
- Lindsy McLean, Head Trainer, University of Michigan
- Clint Thompson, Head Trainer, Michigan State University

Conference Program Chairman: Lanny Johnson, MD, East Lansing

* * *

Chairman, MSMS Comm. on Medical Aspects of Organized Athletics: Robert Evans, MD, Sturgis

* * *

The Michigan State Medical Society has made application so doctors who attend may earn Category I Continuing Medical Education toward the new state requirements

12:00 Luncheon Program:
- Gus Ganakas, Basketball Coach, Michigan State University

1:30 Afternoon Program:

Subject: "The Value of Arthroscopy in Diagnosis"
- Lanny Johnson, MD, orthopedic surgeon, East Lansing

Subject: "Evaluation of the Knee: Signs of Significant Problems"
- H. Royer Collins, MD, Cleveland

"Practice of Sideline Medicine"
- Gerald A. O'Connor, MD, U-M Team Physician, Ann Arbor

"Ask the Coaches" (A Question and Answer Panel Program)
- A panel of high school and college coaches

4:00 Adjournment

REGISTRATION FORM

Please return to: Michigan Conference on Medical Aspects of Organized Athletics
Michigan State Medical Society
P. O. Box 950, East Lansing, Michigan 48823 Phone: 517/337-1351

I would like to register for the April 1 Conference

Name ______________________________

Check one: Physician ________ Coach ________ Trainer ________ Other ________

Address ______________________________

City ______________________ State ______________ Zip ______________

My check for $__________ ($7 per person) is enclosed. The conference fee of $7 covers the program, luncheon and coffee breaks.

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MSU Program enthuses UP doctors helping to train rural family MDs

By Judith Marr
Managing Editor

Paul Werner, MD, Escanaba, thinks he has "A fantastic job." He is preceptor-coordinator of Michigan State University's Upper Peninsula Medical Education Program.

"What a challenge!" he says of his position as teacher of the 10 MSU medical students enrolled in the UPMEP, who are being trained as family physicians. Doctor Werner, a graduate of the MSU College of Human Medicine, also is the only licensed MD at the center and thus is in charge of all care delivered there.

The medical education program is a unique approach undertaken by MSU to train rural family physicians in a setting remote from campus and like that in which they'll practice. MSU also hopes those students will remain to practice in the physician-poor UP.

The MSU experiment has attracted national attention as a model for training and increasing numbers of rural physicians.

The students act almost as residents at the center, learning and delivering basic care at the same time. They do not attend lectures, but learn through a combination of small-group problem solving sessions, tutorial sessions, and self-study with a variety of audio-visual materials. Their patient contact begins in the first year and continues throughout their four-year course.

The patients at the center are drawn from a cross-section of the population to represent a typical family-practice load. Business procedures, referrals and fees are structured after those of a typical family practice.

Doctor Werner Suits Program's Goals

Doctor Werner appears to have been a perfect choice for heading the experimental educational program.

He and his wife, Jane, a home economist, already had determined to live and work in the UP. When the offer came from MSU, it was "like falling into a bed of roses," he says.

Not only was it the location they wanted, but it offered the chance to teach, which Doctor Werner wanted, but had been afraid he would have to forego by locating in the UP.

There are parallels between the Werners' experience and the program's intents and purposes.

The students, besides passing the regular requirements for entry into the College of Human Medicine, must have direct ties with the UP, so they are more likely to stay there after medical school.

An informal poll in December revealed that more than half of the students are planning to practice family medicine in the UP and the rest "are leaning in that direction."

"They talk of towns from Ironwood in the west to the Soo in the east," says Dr. Werner. "They should be well scattered in their practices."

The program brought the Werners to Escanaba. And proponents expect it will increasingly influence top-notch persons and educational programs to locate in the UP. There is talk already of a second such medical education module to be established in the UP.

Ronald Richards, PhD, UPMEP program director, believes the program will enhance physician recruitment for the UP, as there will be opportunity for physicians to teach, to associate with outstanding medical personnel and to be part of a university program.

Original 10 Students Still with UPMEP

There have been no dropouts from the original 10 students who enrolled in January, 1975. "I think we're going to turn out 10 doctors," says Doctor Werner. "Our students are equal academically with their counterparts on campus. No one is in trouble."

On the contrary, because patients are so accessible to the students, Doctor Werner rates the UPMEP classmates as advanced.

"The beautiful thing is to see them be able to apply what they just learned the previous week. They really are starting to be astute diagnosticians. They can think on their

Doctor Werner

Doctor Hockstad, right, and students examine patient.

feet. They're learning to handle patients, schedule tests, determine follow-up; in short, to be family physicians.

"I think the concept's working, and it is possible to run a top-notch program in northern Michigan. We couldn't do it without the university, but we can as long as we have their resources available to us."

His assessment is shared by Raymond Hockstad, MD, Escanaba family physician and original head of the Upper Peninsula Health Education Corporation, which administers the MSU program. Doctor Hockstad was instrumental in getting the program to the UP. Now he and Carl F. Hammerstrom, MD, Marquette internist, are employed on a quarter-time basis as instructors for the program.

In addition, there are four quarter-time instructors in basic science disciplines with the program.

"I think the program's doing fantastically," says Doctor Hockstad.

Doctor Hockstad is particularly pleased with the large amount of patient contact with the program's departure from segmental, compartmentalized medical education, with the emphasis on practical application of medical knowledge. He sees great excitement in training physicians in the practicalities of rural practice who can fill the need in any section of the country.

Doctor Richards believes the cooperation of the community with the university is a major strength of the program.

The community, according to Doctor Werner and Doctor Hockstad, has received the program exceptionally well. Local physicians, they say, go out of their way to bring interesting cases to the students' attention, to include them in conferences, to be friendly. (30 UP physicians have participated so far in the planning, teaching and student selection.)

Of approximately 900 patients seen so far at the center, only two have refused to be seen by students, says Doctor Werner.

Curriculum Planning New Projects Underway

Instead, the center has evidently gained such a good reputation for medical care in the area that it can't handle all the requests from patients for treatment.

"To be fair, we've had to deny all new requests for a period of time," says Doctor Werner. "As we're also a teaching institution, we have to limit our patient care services."

Doctor Werner is now recruiting a partner to help him shoulder the teaching-practicing load, and hopes to have another MD at the center by summer.

"The job keeps me busy, between committee work, hospital responsibilities, teaching, curriculum development, and delivery of care. We need another full-time faculty member."

Program faculty are hard at work now planning the third and fourth-year curricula for the program, as the students will begin their third medical school year this summer.

"We have to be flexible, enable the students to learn what they need to practice here, and yet be competent physicians anywhere.

"The lock-step rotations of the standard medical school curriculum are not appropriate or possible here," adds Doctor Werner. "We don't have the resources."

A number of projects also are underway at the center, where every procedure is "analyzed 16 ways" by computers, according to Doctor Werner.

The center hopes to determine how physician-extenders can aid UP physicians, who have a 40% greater-than-average patient load; and to use physicians' record systems to assess quality of care, set up automatic preventative care screening systems and serve as prods for improving care. All such projects are aimed at helping the rural family physician.

Program personnel are working to establish a public health education center with local hospitals and to organize a consortium of hospitals under the program's umbrella to offer approved CME courses for physicians. A post-graduate residency program in family practice in the UP also is planned.

The major criticism of the program so far, according to Doctor Hockstad, has been its cost, which is now twice per student that of other medical schools.

"But that is the start-up cost," he explains. "Next year we will be adding another 10 students to the program, without much additional cost. Eventually, the cost should be much less than traditional medical schools, as our cost for facilities is minimal.

"This type of program utilizes the facilities already here, to a large extent. We just need a relatively inexpensive conference and study area, and a family practice clinic that is self-sustaining."

Summary of Actions — Michigan Medical Practice Board

By Sherry Wellman, MSMS Liaison with Governmental Agencies

Meeting of January 7

1. Approved licensure by endorsement of Oklahoma for George H. Ishler, MD.

2. Approved licensure by endorsement of Oregon for Frank Blaine Jolley, MD.

3. Heard a progress report from the Department of Licensing and Regulation on the formation of the Medical Sciences Unit which will consolidate the complaint and investigation process for the professions of medicine, osteopathy and podiatry. New personnel for the Unit will include a chief, five investigators, one secretary and three clerks. The Board remains concerned whether the funds necessary to support the Unit will be forthcoming.

4. Heard a presentation by the Straith Memorial Clinic requesting Board approval for a residency training program in plastic surgery. The Board will take the request under advisement.

5. Approved a draft letter of response to complaints regarding excessive fees wherein the Board acknowledges its lack of jurisdiction over fees and refers the individual to the component medical society or small claims court.

6. Requested advice from the Office of the Attorney General regarding the ruling of the Federal Trade Commission that statutes prohibiting professional advertising constitute an unfair restraint of trade.

7. Heard a report from Sherry Wellman, MSMS, on the proposed Health Occupations Article of the Public Health Statutes Revision Project.

8. Discussed proposed legislation for physicians' assistants and related amendments to the Medical Practice Act.

9. Approved the issuance of an official letter of reprimand to Sun Hyoo Kim, MD, formerly of Owosso, for improper dispensation of amphetamines in anticipation of an inquiry from the Texas Board of Medical Examiners.

10. Reviewed the quarterly report from the consulting psychiatrist regarding the limited licensure of Robert S. Nixon, MD.

Meeting of February 5

1. Reviewed the results of the December FLEX examination which showed that of 543 people taking the exam (both new and rewrites), 300 passed and 243 failed. The failure rate is thus 44.5 per cent. Foreign medical graduates accounted for 233 failures. Six graduates of Guadalajara took the exam and one failed.

2. Approved a settlement agreement in the case of Steven Tarangle, MD.

3. Approved a recommendation from the Office Management Subcommittee that in the future, notification of all final orders of disciplinary actions be sent to MSMS, Michigan Hospital Association and all third-party carriers in addition to governmental agencies.

4. Received a report from the Investigation Subcommittee on the status of open files under investigation and on those closed out because of lack of sufficient substantiation.

5. Requested advice on what constitutes a reasonable payment for the services of expert witnesses appearing before the Board in contested cases.

6. Approved a report from the State Legislation and Budget Committee on recommended amendments to the Medical Practice Act and positions on other legislation affecting the administration of the Board.

7. Received the quarterly report from the supervising physician regarding the limited licensure of J. Maxwell Cook, MD.

8. Authorized an investigation into the matter of Hughes vs. Reizen and Rice wherein the Michigan Department of Public Health is alleged to employ unlicensed personnel who are practicing medicine without a license.

9. Approved the reinstatement of medical licenses which had lapsed for more than five years, upon payment of all relevant fees to Donald B. Effler, MD and Almarose Cooke Worden, MD.

10. Found no authority in the new Medical Practice Act to approve or disapprove a request from Butterworth Hospital of Grand Rapids to employ an individual as a surgeon's assistant.

11. Discussed implementation problems of the 50 hour requirement for continuing medical education for licensure in 1977. The Board was informed of MSMS progress in the accreditation of institutions to offer Category I CME credit and the development of programs to assist physicians to meet the requirement.

12. Reviewed the status of contested cases with legal counsel and rescheduled several hearing dates to accommodate defendants.

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3. Threatened abortion.

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Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

category 1 programs

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

Date: March 15-16, 1976 — Oncology for the Practicing Surgeon

Location: U-M, Towsley Center, Ann Arbor, 48109

Sponsor: Department of PGM/HPE

For: General Surgeons

Cost: Practicing Physicians $130
Physicians-in-Training $65

Contact: Floyd Pennington, Ph.D.**

Approved for: 14¾ hours of Category I Credit

* * *

Dates: March 17-18, April 7-8, May 12-13 — Quality Assurance Tutorial

Location: Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, 48105

Sponsor: CPHA

For: PAS member hospital teams

Cost: Hospital team of five members, $155
For additional members: $35

Contact: CPHA

Approved for: 13 hours of Category I Credit

* * *

Date: March 24-25 — 15th Annual Michigan Conference on Maternal and Perinatal Health

Location: Kalamazoo Center Inn, Kalamazoo

Sponsor: Michigan State Medical Society

Co-Operating: Perinatal Association of Michigan; Michigan Section, NACOG, District V, American College of Obstetricians and Gynecologists

For: Physicians and nurses interested in maternal and perinatal health.

Costs: No registration fee; March 24 banquet, $11.

Contact: Herbert A. Auer, MSMS, 120 W. Saginaw, East Lansing, 48823

Approved for: Application is pending for Category I credit (Watch Medigram for future announcements)

* * *

Date: March 25 — Pharmacological Control of Immediate Hypersensitivity and Asthma (9:00 — 10:00 AM)

Location: Sparrow Hospital, Lansing

Sponsor: Sparrow Hospital

For: Interested physicians

Costs: No fee

Contact: Richard W. Pomeroy, MD, Director of Medical Education, Sparrow Hospital, Lansing 48902

Approved for: 1 hour of Category I Credit

* * *

Date: March 29-31, 1976 — Human Allergy: Management

Location: U-M, Towsley Center, Ann Arbor, 48109

Sponsor: Department of PGM/HPE

For: Internists, Pediatricians, Family Physicians

Cost: Practicing Physicians, $150
Physicians-in Training, $75

Contact: Robert K. Richards, Ph.D.

Approved for: 21¼ hours of Category I Credit hours

* * *

Date: March 31 — Family Practice Conference on Hyperlipidemia

Location: Sparrow Hospital, Lansing

Sponsor: Sparrow Hospital

For: Interested Physicians

Costs: No fee; luncheon preregistration limited to 70

Contact: Richard W. Pomeroy, MD, Director of Medical Education, Sparrow Hospital, Lansing 48902

Approved for: 4 hours of Category I Credit

* * *

Date: April 1 — Annual Conference on Medical Aspects of Organized Athletics

Location: Long's Convention Center, Lansing

Sponsor: Michigan State Medical Society

For: Team physicians, trainers, coaches

Cost: Luncheon

Contact: Herbert A. Auer, MSMS, 120 West Saginaw, East Lansing 48823

Approved for: Application is pending for Category I Credit (Watch Medigram for future announcements)

* * *

Date: April 5-30, 1976 — Surgical Anatomy Review

Location: U-M, Towsley Center

Sponsor: Department of PGM/HPE

For: Surgeons

Cost: Practicing Physicians $350
Physicians-in-Training $350

Contact: Robert K. Richards, Ph.D.*

Approved for: Category I Credit hours to be determined

* * *

Date: April 6-7, 1976 — Obstetrics & Gynecology Conference

Location: U-M, Towsley Center, Ann Arbor, MI 48109

Sponsor: Department of PGM/HPE

For: Obstetricians, Gynecologists

Cost: Practicing Physicians — Undetermined
Physicians-in-Training — Undetermined

Contact: Robert K. Richards, Ph.D.*

Approved for: 10 hours of Category I Credit

* * *

Date: April 7-8 — Quality Assurance Tutorial (See description under March 17-18)

* * *

Date: April 7-June 16, 1976 — Clinical Radioisotope, Theory and Application (2 hours weekly)

Location: WSU Scott Hall

Sponsor: Wayne State University, Dept. of Pathology

For: Hospital pathologists

Cost: $154

Contact: WSU Continuing Medical Education, 1206 Scott Hall, 540 East Canfield, Detroit 48201

*****Approved for:** Hour-per-hour of instruction

* * *

Date: April 9-10, 1976 — Ninth Annual Cancer Symposium: Cancer of the Prostate
Location: WSU Scott Hall
Sponsor: Wayne State University, Dept. of Oncology
For: Urologists, Surgeons, others
Cost: $25
Contact: WSU Continuing Medical Education, 1206 Scott Hall, 540 East Canfield, Detroit 48201
***Approved for: 12 hours, Category I.

* * *

Date: April 20-22, 1976 — EKG Diagnosis
Location: U-M Towsley Center
Sponsor: Department of PGM/HPE
For: Gen. Practitioners, Internists
Cost: Practicing Physicians, $150
Physicians-in-Training, $150
Contact: Robert K. Richards, Ph.D.*
Approved for: 21 hours of Category I Credit

* * *

Date: April 29-30 — Annual Critical Care Symposium — Newer Concepts in the Management of the Critically Ill
Location: Wayne County Medical Society, 1010 Antietam, Detroit
Sponsor: Wayne State University, Dept. of Surgery
For: Surgeons, Nurses
Cost: $90 for physicians; $45 for nurses
Contact: WSU Continuing Medical Education, 1206 Scott Hall, 540 East Canfield, Detroit 48201
***Approved for: 20 hours, Category I

* * *

Date: May 6-7 — 19th Annual Clinic Days — Symposium on Pediatric Drug Therapy
Location: Children's Hospital, Detroit
Sponsor: Wayne State University, Dept. of Pediatrics
For: Pediatricians
Cost: $100
Contact: WSU Continuing Medical Education, 1206 Scott Hall, 540 East Canfield, Detroit 48201
***Approved for: 14 hours, Category I

* * *

May 6-7, 1976 — Ophthalmology Conference
Location: U-M, Towsley Center Ann Arbor, 48109
Sponsor: Department of PGM/HPE
For: Ophthalmologists
Cost: Practicing Physicians, $130
Physicians-in-Training, $130
Contact: Robert K. Richards, Ph.D.*
Approved for: 14 hours of Category I Credit

* * *

Date: May 7-8, 1976 — Board Review in Nuclear Medicine
Location: U-M Towsley Center, Ann Arbor, 48109
Sponsor: Department of PGM/HPE
For: Radiologists
Cost: Practicing Physicians — $110
Physicians-in-Training — $60
Contact: Floyd Pennington, Ph.D.**
Approved for: 16½ hours of Category I Credit

* * *

Date: May 11, 1976, Continuing Pathology Conference
Location: U-M, Towsley Center
Sponsor: Department of PGM/HPE
For: Pathologists
Cost: Practicing Physicians and Physicians-in-Training $10 per session
Contact: Robert K. Richards, Ph.D.*
Approved for: 6½ hours of Category I Credit

* * *

Date: May 12-13 — Quality Assurance Tutorial (See description under March 17-18)

* * *

Date: May 13-14, 1976 — Advances in Cardiac Pacing
Location: U-M, Towsley Center Ann Arbor, 48109
Sponsor: Department of PGM/HPE
For: Cardiologists, Thoracic Surgeons
Cost: Practicing Physicians, $120
Physicians-in-Training, $60
Contact: Robert K. Richards, Ph.D.*
Approved for: 14¾ hours of Category I Credit

* * *

Date: May 17-21, 1976 — Advances in Internal Medicine
Location: U-M, Towsley Center, Ann Arbor, MI
Sponsor: Dept. of PGM/HPE, University of Michigan
For: Internists, Family Physicians
Cost: Practicing Physicians $220
Physician-in-Training —$110
Contact: Robert K. Richards, Ph.D.*
Approved for: 25-30 Hours of Category I Credit

* * *

Date: May 22 — "Unexpected Childhood Deaths"
Location: Sparrow Hospital, Lansing
For: Interested physicians
Costs: No registration fee
Contact: Richard W. Pomeroy, MD, Director of Medical Education, Sparrow Hospital, Lansing 48902
Approved for: 4 hours of Category I Credit

* * *

Date: June 7-11 — Principles and Practice of Industrial Toxicology
Location: Hyatt Regency, Dearborn
Sponsor: Wayne State University, Dept. of Occupational and Environmental Health
For: Industrial physicians, public health officials, hygienists, others
Cost: $350
Contact: WSU Continuing Medical Education, 1206 Scott Hall, 540 East Canfield, Detroit 48201
***Approved for: 14 hours, Category I

* * *

Date: June 30-Sept. 8 — Instrumentation in Clinical Biochemistry (2 hours weekly)
Location: WSU Scott Hall
Sponsor: Wayne State University, Dept. of Pathology
For: Hospital pathologists
Cost: $154
Contact: WSU Continuing Medical Education, 1206 Scott Hall, 540 East Canfield, Detroit 48201
***Approved for: Hour-per-hour of instruction

---

*Robert K. Richards, PhD, Director, Office of Intramural Education, University of Michigan Medical Center, Dept. of PGM/HPE, Ann Arbor, 48109.

**Floyd Pennington, PhD, Assistant Director, Office of Intramural Education, University of Michigan Medical Center, Department of PGM/HPE, Ann Arbor, 48109.

***WSU request for accreditation is before AMA.

MEETINGS

See list of Category I programs on page 136

March 10 — MSMS Council, at MSMS Headquarters, contact: Warren F. Tryloff

March 24 — MSMS Auxiliary Legislative Day, at Olds Plaza, Lansing, contact: Jackie VanDeventer, MSMS Headquarters

March 24 — March meeting, "Insulin Allergy," Michigan Allergy Society, at The Lion's Den, Lansing, contact: B. David Wilson, MD, MAS, Sec., 4615 W. Main St., Kalamazoo 49007.

March 24-25 – 15th Annual Michigan Conference on Maternal and Perinatal Health at Kalamazoo Center Inn, Kalamazoo, contact: Herb Auer, MSMS Headquarters.

March 27 – Mediterranean Night, dance and entertainment sponsored by WCMS Auxiliary, at Armenian Cultural Bldg., 22001 Northwestern Highway, Southfield, $25 per person, contact: Mrs. Emil J. Alban, reservations chairman, 3 West Lane, Dearborn, 48124.

March 31 — Symposium — "Rheumatology for the Clinician," sponsored by Borgess Hospital, Michigan Arthritis Foundation and SW Michigan Area Health Education Center, at Kellogg Center, Kalamazoo, contact: H. R. Mena, MD, 1521 Gull Road, Kalamazoo 49002.

April 1 — Medical Practice Board, at 1116 So. Washington Ave., Lansing, contact: Bert C. Brennan, 1033 S. Washington Avenue, Lansing 48926.

April 1 – Michigan Conference on Medical Aspects of Organized Athletics, at Long's Convention Center, Lansing, contact: Herb Auer, MSMS Headquarters.

April 3-4 — AMA Detroit regional continuing medical education meeting, Michigan Inn, Southfield, contact: William L. Simpson, MD, director, Continuing Medical Education, Wayne State University, Scott Hall, 540 E. Canfield, Detroit 48201

April 5 — Annual Beaumont Lecture by Dwight E. Harkan, MD, Boston, "The American Doctor During Two Centuries," at Wayne County Medical Society, Detroit, contact: Roger Mecum, WCMS, 1010 Antietam, Detroit 48207

April 8-9 — Seventh Annual Maternal and Child Health Colloquium, sponsored by U-M School of Public Health, at the Rackham Building, U of M campus, Ann Arbor, contact: Winnie O. Willis, Room M5015, Thomas Francis Building, The University of Michigan, Ann Arbor 48104

April 8-10 — Conference on Otolaryngology, sponsored by MSU Department of Surgery, Division of Otolaryngology, at Kellogg Center, East Lansing, contact: Ann E. Tsiminakis, 24 Kellogg Center, MSU, East Lansing 48824

April 11-12 — AMA-AMPAC Public Affairs Workshop, Shoreham Hotel, Washington, D.C., contact: John Richards, MSMS Headquarters

April 12 — Annual MDPAC Congressional Reception, Capitol Hill Club, Washington, D.C., contact: John Richards, MSMS Headquarters

April 15 — General meeting and election of officers, Michigan Ophthalmological Society, 5:30 p.m. reception at Wayne County Medical Society Headquarters, contact: Phillip Hessburg, MD, sec., MOS, 15401 E. Jefferson, Grosse Pte. Park 48230

April 26-30 — AMA Seminar on Negotiations, at Hillsdale College, (Fee: $750, including room and board), contact: Department of Negotiations, AMA, 535 N. Dearborn, Chicago 60610

April 29-30 — Annual Heart Days, sponsored by Michigan Heart Association, at Hyatt Regency Hotel, Dearborn, contact: Dennis Hampton, PO Box LV160, Southfield 48076

April 29-May 1 — Critical Care Symposium at Wayne County Medical Society Headquarters, 1010 Antietam, Detroit, contact: Don Burkholder, WSU University Relations School of Medicine, 540 E. Canfield, Detroit 48201

April 30 and May 2 — The Council, Troy Hilton, contact: Warren Tryloff, MSMS Headquarters

April 30-May 2 — MSMS House of Delegates, Troy Hilton, contact: Richard Campau, MSMS Headquarters

May 4 — Michigan Cancer Coordinating Committee meeting, MSMS Headquarters, contact: Helen Schulte, MSMS Headquarters

May 12-14 — Joint Michigan/Ontario Chapter Meeting, American College of Emergency Physicians, at Four Seasons Hotel, Toronto, Ontario, contact: ACEP, 241 E. Saginaw, East Lansing 48823

May 14-16 — Central States Meeting, Michigan Dermatological Society, at Hyatt Regency, Dearborn, contact: James D. Stroud, MD, 15901 W. Nine Mile Rd., Southfield 48075.

May 19 — Annual Meeting, Michigan Allergy Society, contact: B. David Wilson, MD, Sec., MAS, 4615 W. Main St., Kalamazoo 49007

May 19 — 108th Annual WSU Medical Alumni Reunion Day, Michigan Inn, Southfield, contact: Don Burkholder, WSU University Relations-School of Medicine, 540 E. Canfield, Detroit 48201

May 27-28 — Committee on Maternal and Perinatal Health, Gull Lake, MSU Conference Center, contact: Helen Schulte, MSMS Headquarters.

June 2-3 — Practice Management Workshop jointly sponsored by MSMS and AMA. Michigan Inn, Southfield, contact: John Anthony, MSMS headquarters

June 2-4 — Annual Meeting, Michigan Public Health Association, Grand Hotel, Mackinac Island, contact: LaRue Miller, executive director, MPHA, 403 Seymour, Lansing

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HEARTBEAT

William H. Blodgett, MD, Detroit, is the new president of the American Orthopaedic Foot Society, an affiliate of the American Academy of Orthopaedic Surgeons. Elected at the group's annual meeting in New Orleans last month, Doctor Blodgett is also former academy public relations chairman. He is co-chairman of the WCMS Beaumont Lecture Committee, a clinical associate professor of orthopedics at WSU School of Medicine and attending orthopedic surgeon at Children's Hospital of Michigan, Detroit Orthopedic Clinic, Rehabilitation Institute of Metropolitan Detroit and Herman Keifer Hospital.

Lee Feldkamp, MD, Plymouth, is actively serving on the board of directors of the American Academy of Family Physicians following his successful campaign and election late last year. A past president of the Michigan Academy of Family Physicians, Doctor Feldkamp was also the Michigan Family Physician of the Year for 1974. Long active in the Wayne County Medical Society, Doctor Feldkamp is now chairman of the AAFP Commission on Membership and Member Services.

* * *

Frank B. Heckert, MD, Lansing, ophthalmologist, is ending a 41-year career as an eye surgeon, partly because of malpractice insurance costs. As Doctor Heckert puts it, "I would still like to have a part-time practice. But working part-time is impossible now, due to the killing cost of malpractice insurance."

* * *

John Moses, MD, Wayne County Medical Society president and member of the Michigan Medical Practice Board, has been named to the Michigan Advisory Commission on Physicians Assistants by Governor Milliken. As director of medical education at Mt. Carmel Mercy Hospital, Doctor Moses has been actively working with the Mercy College Physician Assistant program since its inception.

* * *

E. Dewain Silvernale, MD, a Berrien County pediatrician, is in Haiti leading a campaign to vaccinate over one million people against tuberculosis. On a two-year leave of absence from his practice, Doctor Silvernale is serving as director of the Grace Children's Hospital in Port-Au-Prince in addition to heading 40 volunteers in the massive vaccination program expected to take four

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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years. Doctor Silvernale previously worked in Haiti in 1962 and from 1966 to 1969 as a medical missionary.

* * *

Alfred B. Swanson, MD, Grand Rapids, orthopedic surgeon known for his work in artificial joint development, was guest lecturer at two recent national meetings. He spoke on "Prosthesis in the Treatment of Trauma and the Rheumatoid Hand" at a Chicago meeting of the American Society for Surgery of the Hand. He also was a lecturer at a meeting of the American Academy of Orthopaedic Surgeons in Williamsburg, Virginia where his topic was "Joint Reconstruction in Association with Tendon and Muscle Reconstruction."

* * *

Alexander J. Walt, MD, and Robert F. Wilson, MD, Detroit, with the help of 41 colleagues on the WSU faculty, have published a comprehensive volume entitled, *Management of Trauma: Pitfalls and Practice* which was reviewed in the *JAMA* on Jan. 26.

1975-76 Wayne County Medical Society President Louis E. Heideman, MD, right, accepts the WCMS past president's plaque from James C. Danforth, MD, chairman, WCMS board of trustees. Doctor Heideman has been succeeded by John W. Moses, MD (see page 153).

Peter A. Martin, MD, Southfield, became president of the American College of Psychiatrists on January 31, at the group's 14th annual meeting. Doctor Martin was the first Charter Fellow of the College and served as secretary general for three years. He is clinical professor of psychiatry at both the U-M and WSU medical schools.

Bruce A. Work, Jr., MD, Ann Arbor, associate professor of obstetrics and gynecology at the University of Michigan Medical School, is the first U-M physician to receive certification in maternal-fetal medicine from the American Board of Obstetrics and Gynecology. There are only 38 other such certified physicians in the United States.

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Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide	0.075 mg
Calcium (from Dicalcium Phosphate	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

ACTION AND USES — DOSAGE: 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets. Rx only.

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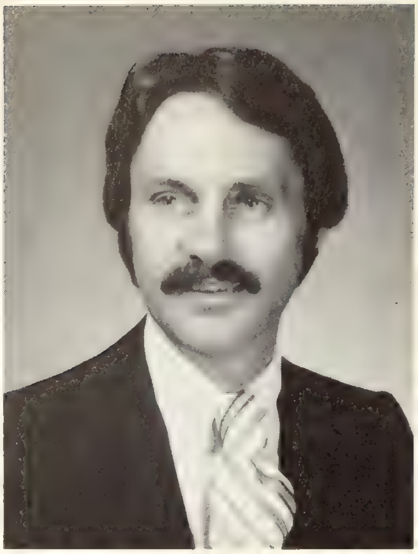
New Wayne County director reflects on first few months


Mr. Mecum

The new executive director of the Wayne County Medical Society — who is the first executive director of the WCMS — has been working 14 hour days and finds his initiation "exhausting."

But "I'm enjoying it," says Roger Mecum, formerly associated with the District of Columbia Medical Society. And his dedication is obvious.

He's working at learning names ("You can only ask once or twice, you know"), medical society relationships, continuing programs and WCMS history.

He and his wife, Judy, have been researching the last seven years of WCMS Council policy decisions ("We have to see where we've been and where we're going.")

And he's been picking up the many new duties his job entails, such as sitting in on four major committee meetings ("that alone is a full-time job"); and serving as executive for the former Wayne County Health Foundation, now the Else Kolhede Memorial Foundation. ("The foundation meets once a year, and the background work for that meeting alone takes a tremendous amount of time.")

In addition, as Wayne County never had an executive director before, Mr. Mecum has been expanding that position from the former executive secretaryship. He prepared a two-page job description at the time of his hiring and declares that "I have to tell the members as much about the possibilities of this position as they tell me. We're learning together."

The handsome, dark-haired Mr. Mecum declared his first major WCMS activity, coordination of the annual WCMS dinner dance Dec. 12, "a mind-boggling, exhaustive, administrative experience." The dinner-dance, to kick off the Bicentennial Year, was held in the Detroit Library, with cocktail reception in the Rare Books Room. Meals were cooked over 200 sternum fires by caterers headquartered on the loading dock.

But Roger, who joined WCMS on Nov. 17, is excited by the prospects of the medical society's possibilities.

"I want to bring the doctors together, and provide more unity." He's cognizant, at the same time, that "politics in the Wayne County Medical Society are unique."

"This is the fifth largest county medical society in the country. It can have great influence."

Mr. Mecum is 31, married, a graduate of the University of Illinois College of Journalism and Communications. He is a former public school teacher, and freelance editor. He is also a former executive director of the District of Columbia Society of Internal Medicine. While with the District of Columbia Medical Society he was responsible for governmental liaison, administering the DC Political Action Committee and publication of the official society publication.

PAUL J. CONNOLLY, MD, Detroit, retired in January to end a 35 year career as a surgeon at Harper Hospital. He served as director of medical affairs for the 680-bed hospital since 1972. Doctor Connolly is currently co-chairman of the Wayne County Medical Society's ethics committee.

* * *

SIDNEY FRIEDLAENDER, MD, Southfield allergist, presented the Stanislaus H. Jaros Memorial Lecture at the annual meeting of the American Association for Clinical Immunology and Allergy in Palm Springs, California recently.

* * *

RAY E. HELFER, MD, East Lansing, has been named to the board of directors of the National Committee for Prevention of Child Abuse, a private, non-profit US organization. A nationally-recognized authority. Doctor Helfer has authored two books, *The Battered Child* and *Helping the Battered Child and His Family.*

* * *

DONALD B. KAUFMAN, MD, East Lansing, Assistant professor of human development at the MSU College of Human Medicine, has been awarded a NIH grant to develop and sponsor a national conference on bone marrow transplantation in children.

* * *

CLARENCE S. LIVINGOOD, MD, Detroit, received the Gold Medal of the American Academy of Dermatology at the Academy's recent annual meeting in San Francisco. Doctor Livingood, the first Michigan recipient, is chairman of the Department of Dermatology at Henry Ford Hospital and was awarded the honor for outstanding contributions to dermatology.

* * *

KATHRYN RICHARDS, MD, Ann Arbor general surgeon, was featured in a recent issue of *Vital Signs*, the monthly publication of St. Joseph Mercy Hospital. The interview was part of a feature recognizing women's contributions to society as part of International Women's Year. Doctor Richards is assistant director of the U-M Burn Center and is an assistant professor of surgery at the U-M Medical School.

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Warnings: Do not use excessively.

Precautions: Administer with caution and adjust to the requirements of the individual patient. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis. ***Patients should be cautioned to adhere to dilution instructions.***

Adverse Reactions: Potassium intoxication indicated by listlessness, mental confusion, paresthesia of the extremities, weakness of the legs, flaccid paralysis, fall in blood pressure, cardiac depression, arrhythmias, arrest and heartblock. Vomiting, nausea, abdominal discomfort and diarrhea may occur.

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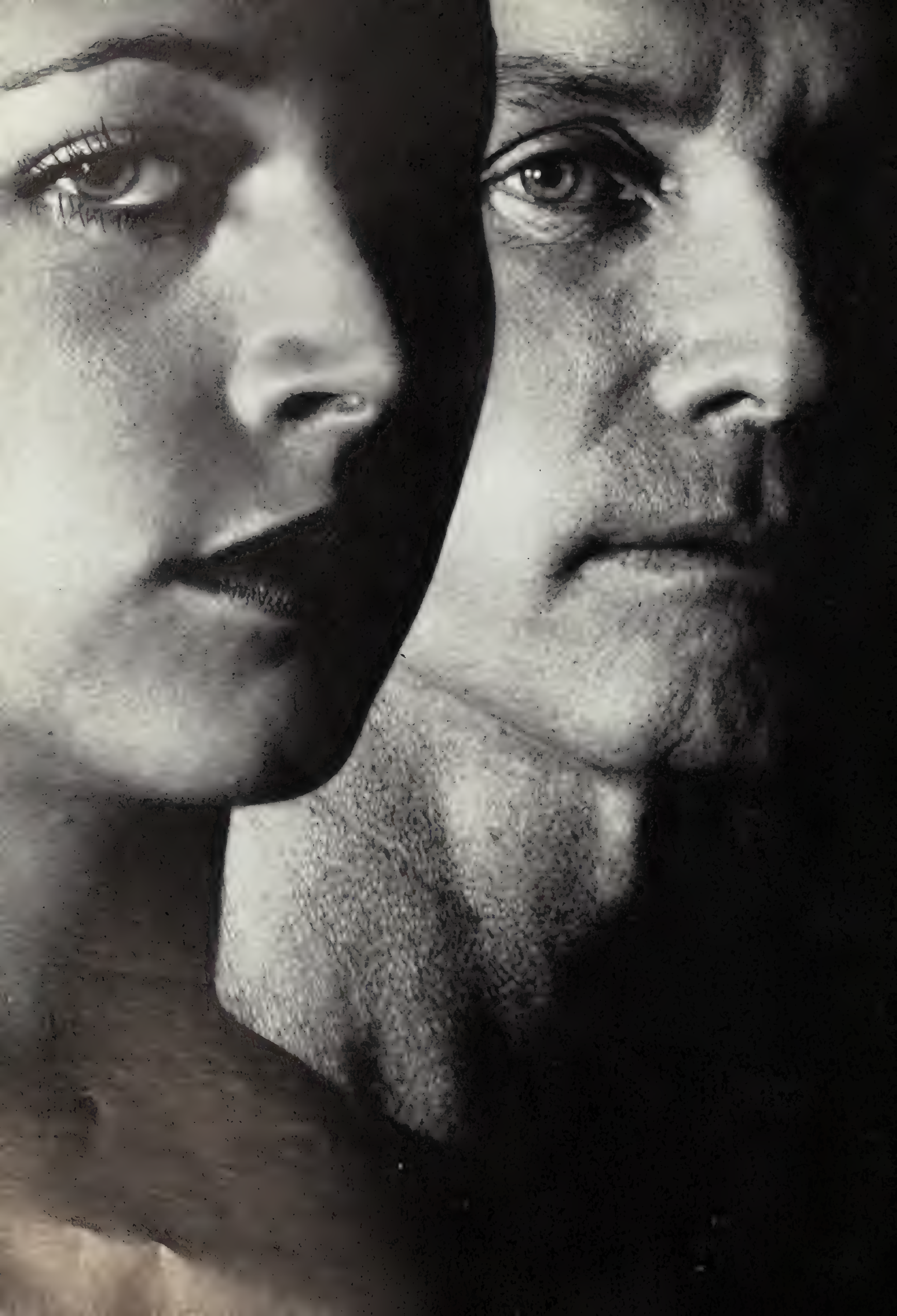

Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A

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Association
1155 Fifteenth Street, N.W.
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Do you support or oppose federal legislation to control residency training programs?

By Scott N. Swisher, MD
East Lansing

I am convinced there is an urgent need to develop national policies which will control the disciplinary distribution of residencies, numerically and geographically. It is one approach to the major problem presented by the present medical manpower maldistribution.

Although I do not favor doing this by legislation, this approach, in one form or another, now seems almost inevitable. Federal legislation should be the last resort for the solution of such problems in a responsible, free and self-regulating society. Legislation is now an unfortunately popular first consideration. The flood of poorly conceived and unwise laws which attempt to regulate most aspects of contemporary life speaks more than can be said in these pages against this approach.

Doctor Swisher

Nevertheless, the task must be done. The question is, who can and will do it?

It has been obvious for at least five years that the process of allocating American medical manpower by specialties and geographically has required revision to meet urgently and clearly stated public needs. Little of substance has been accomplished beyond development of the family practice movement as it currently stands. Entry into the various medical specialties continues to be influenced greatly by the need for manpower within the so-called training institutions, rather than by need for the resulting specialists in the delivery of health care.

Alternatives to the use of residents for that manpower need have not been considered adequately. The large and prestigious clinical training centers, which are not uniformly distributed across the country, continue to grow, further contributing to the geographic maldistribution of physicians, since place of training so strongly influences location of practice. Institutions which have attempted to develop distributed community-based training programs, focused largely on primary care, have received a great deal of verbal support from some quarters, but very little of the realistic support needed to do this big job.

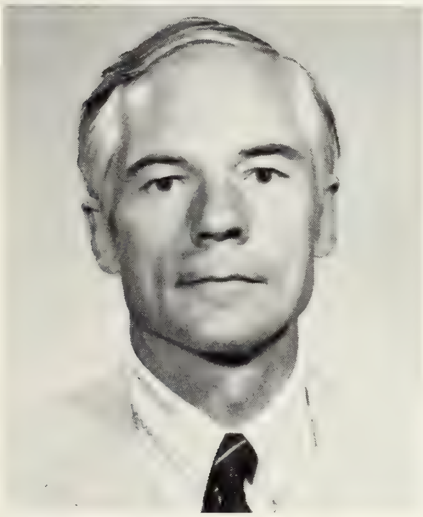
The job of redistributing medical manpower has not been done; indeed, the major problems have not even been joined. This makes it more and more certain that federal intervention will be the only way in which these unequivocal demands of the public will be met.

In effect, we will soon have demonstrated to us again the ineffectiveness of our own institutions which should be able to deal with such problems and the lack of leadership responsive to public need in our profession. If we respond now with alternative proposals, it will again be after the fact, under threat of legislation, and after the leadership opportunity has been largely lost.

Accrediting agencies, professional societies, certifying boards and organizations of training institutions should come together urgently on a national basis with intent to solve these complex problems voluntarily and equitably for all.

The first goal must be to meet our country's future medical manpower needs. All other interests are secondary, and self-defeating if they are given first priority.

Doctor Swisher is chairman, Department of Medicine, Michigan State University College of Human Medicine.



Doctor Welch

By Norman L. Welch, MD
Muskegon

It has become increasingly popular in recent years for our legislators to attempt to solve the apparent problems of this country by curtailing the personal liberties of various groups of citizens.

I believe the proposed federal legislation to control the numbers, locations, and types of resident training programs is an example of this approach and is entirely unwarranted. The three goals of the proposed legislation are: (1) alter the distribution of physicians to place more physicians in the undesirable and sparsely populated areas of the country, (2) increase the number of primary care physicians, and (3) limit the number of foreign medical graduates taking resident training and ultimately residing in the United States.

It is true that more resident programs than necessary have been created because of the inherent desire of physicians to teach, the prestige associated with training programs, and the structure of some centers that requires residents for the necessary manpower to function. Also, there certainly is an uneven distribution of physicians in this country, and this is a problem.

The question is whether or not the proposed legislation would help. Part of the reasoning behind the legislation is a study showing that physicians often practice in the state in which they take their postgraduate training. One must remember that this study involved individuals who voluntarily chose the site for their training, and in many cases, the location was chosen because that was where the individual wanted to live.

It is obviously fallacious to conclude that physicians forced into a particular location will stay there after their training is completed. Furthermore, the statistics available deal with distribution by states, whereas the real problem is the distribution of physicians within each state.

I am sure the proposed legislation would be totally ineffective in accomplishing a redistribution of physicians, but I have no good solution to the problem. Very few individuals are going to choose the inner city or small rural communities with inadequate medical facilities as a location for practice. Perhaps it will be necessary to have the Public Health Service provide care in those areas where there truly is no physician within a reasonable distance. Of course, increasing the number of primary care physicians will not put doctors in the undesirable areas since there is an almost universal need for primary care physicians in all communities. Certainly a more even distribution of physicians is desirable but very difficult to achieve.

Changes to increase the number of primary care physicians are already taking place although the effects have not been seen yet. Last year, 55% of all new medical school graduates entered primary care residencies which is a 50% increase since 1968 and represents an absolute increase in addition to the percentage increase. The number of medical schools offering family practice programs has doubled in the past two years. There is no need for legislation in this area.

Each year there are excessive numbers of foreign medical graduates who become permanent residents of this country via loopholes in the immigration laws. Since we have excellent residencies available in this country, and many countries can benefit from having their doctors study in the United States and then return home, I do not think we should close the door to this educational opportunity. The problem of too many of the foreign medical graduates remaining in this country permanently should be dealt with directly by changing the immigration laws and not by limiting the training opportunities.

In conclusion, I believe the problem of insufficient primary care physicians is already being solved. The proposed legislation limiting and controlling resident training programs would be ineffective in changing the distribution of physicians and is the wrong approach to the problem of too many foreign medical graduates establishing practice in this country.

Doctor Welch is a pathologist affiliated with the Muskegon Mercy Hospital.

By John R. Pfeifer, MD
Southfield

I am opposed to any federal legislation which would control and restrict the numbers and locations of residency training programs for various specialties. I believe that residencies should be restricted to quality residencies. However, such supervision and decisions should come from the various specialty societies within organized medicine.

The federal government, on the basis of previous performance, cannot make a good case for being able to skillfully handle the administration of such a program.

It is not comprehensible to me to assume that they would develop a federal bureaucracy with sufficient expertise to properly determine where residencies should be established and the content of such residencies. What we would be creating here is another federal bureaucracy which will be costly and self-perpetrating. Any restrictions and limitations to residency programs should come from within organized medicine itself.

Doctor Pfeifer is chairman, Department of Surgical Services, Providence Hospital, Southfield.

More women medical students would ease primary physician debt

(Editor's Note: This message was developed by Marilyn Heins, MD, associate dean, WSU School of Medicine, for her use over Detroit Radio Station WJR as one of its "Point of View" series. She contends more women medical students would produce more family doctors.)

Nationally last year, nearly 20% of students entering the first year of medical school were women. But currently only 9% of all United States physicians are women. Our country has a lower percentage of female doctors than all other countries except Spain, Madagascar and South Viet Nam.

It is well known to medical educators, as well as the general public, that there is a shortage of physician manpower in our country — a shortage compounded by what is called geographical maldistribution and specialty maldistribution. Simply stated, we have a relative surplus of certain specialists located in urban and suburban areas; but we lack primary care physicians, especially in rural locations, but also in populous areas.

The four members of my own small family go to 11 different doctors and dentists, all located in different areas of the city. My medical knowledge enables me to distribute my family to the correct health provider. What happens to the family that does not know which specialist to seek? What happens to the man who has a stomach ache and is told that his doctor cannot see him for three weeks? Should people use hospital emergency rooms because they cannot find a doctor at night or should we provide more primary care physicians?

"In Michigan, over 50% of the practicing women physicians are in primary care. Nationally, only 43% of male physicians provide primary care. If more women become primary care providers, women physicians may be more likely to meet our current manpower needs. Thus it would be logical to encourage more women to enter medicine.

There are two barriers to this. First of all, there is the old fear that the education of a woman is wasted. But the facts show that nearly 84% of women physicians are in the work force, compared to 93% of male physicians. It simply is not true that women doctors do not practice medicine.

A larger barrier to increasing the number of women doctors has to do with the socialization of women in our society. If indeed Dick and Jane's mother is always in an apron, if the young girl never sees a woman role model wearing a stethescope, and if

(Continued on page 152)

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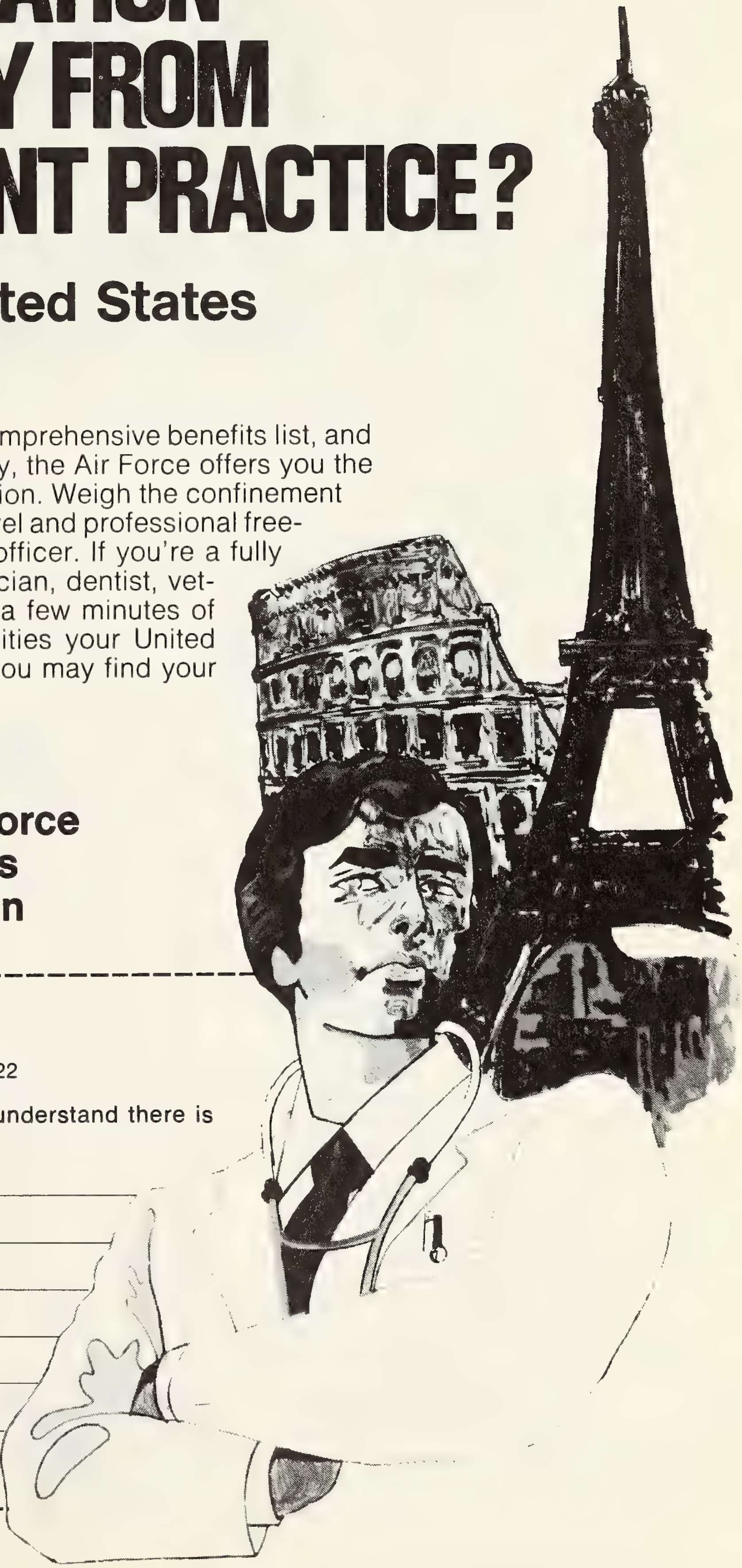
Air Force Medicine



counsellors look at the records, interests and aptitudes of females and males differently — suggesting medical school for the boys interested in health and medical technology for the girls — the number of women in medicine will increase at too slow a rate.

As a medical educator, I am aware that there is no shortage of qualified applicants to medical school. I cannot, and do not, suggest quotas for women, but I am firmly convinced that women can compete with males at college and medical school and that women can and do practice competent, humane medicine. I suggest that we not consciously or unconsciously shut our daughters' eyes to the potential of becoming physicians — or politicians or paleontologists for that matter.

Marilyn J. Heins, MD, WSU associate dean for student affairs, counsels second-year female medical students Lori Adelson, Sue Fraser and Janet Greenhut, left to right.

"In addition to encouraging more females to become doctors, we also should provide part-time training opportunities for those women who wish to combine family and a career. We should increase household help tax deductions for working women as well as provide day-care for children of working mothers.

"Perhaps, in a few years, your doctor will leave her child in nursery school and go to her office to take care of you when you need her."

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New president of the Wayne County Medical Society, John W. Moses, MD, is flanked at his investiture service by MSMS President Brock E. Brush, MD, left, and Ernest L. Griffin, MD, MSMS Council chairman.

We must merit trust

The following paragraphs are excerpted from the recent inaugural address given by new Wayne County Medical Society President John W. Moses, MD.

We must realize the sacred trust that society and history have given us through the years. We must do all we can in our individual relationships with our patients to continue to merit this trust. This implies compassion and understanding — no matter how tired we are of our own problems; continuing eduction — no matter how little we need it; peer review — no matter how right we are; and continuing involvement of other segments of society in medical care — no matter how we resent it.

We must work for unity among ourselves. There are many outside forces attempting to split and conquer medicine as one of the least-regulated bastions of individualism in America today. Splinter groups and specialty groups have attempted within our own ranks to speak for medicine as a whole, while fostering their own vested interests. Frequently, they have done this only at the expense of other segments of the profession. Efforts such as these only assist the powers, be they government, union, or management, who would like to have us under their control.

We have a service the rest of society needs and if we stick together as a group and merit their support we cannot be enslaved.

This implies working together on malpractice, federal legislation, continuing education, registration problems and legislation, health costs, area planning, health care delivery, municipal problems, and the myriad factors affecting our everyday life and the welfare of our practice and our patients.

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Michigan Hospital Association has a new structure

By Patric Ludwig,
President Michigan
Hospital Association

The Michigan Hospital Association (MHA) represents some 240 health care facility providers in the state. Over 95% of the voluntary non-profit hospitals are represented by the Michigan Hospital Association.

It is a trade organization which was reorganized from a shared information and service organization to an organization which is attempting to work more closely with other organized provider associations to influence health care policy developments in Michigan.

This has led it to restructure its resources with primary emphasis on government affairs and health economics. The shared services have been expanded but consolidated into one separately financed division. As the organization chart (below) indicates these divisions are supported by its Public and Association Affairs divisions.

The Division of Health Economics and Finance grew out of the association's internal reorganization earlier this year and reflects the importance of financial matters to hospitals' ability to deliver care. The division was established and based on the premise that the purposes of the association are to influence health care policy in the allocation of resources; to aid in the implementation of such policies; and to assist member institutions in the financial management of their facilities.

While the division, headed by health economist Ken Raske, channels much of its effort in current policy and program areas, it is also the focal point for the association's applied research activities. The Health Economics and Finance Division routinely surveys hospital employees and management compensation practices and has a computerized data file that now extends back a number of years. In addition, the division maintains a Data Retrieval System (DRS) at Michigan State University's Computer Center as a core data base for research. The DRS currently has financial and service information on every hospital in the United States, including socioeconomic characteristics of the population serviced by these hospitals. The DRS will be routinely updated with plans for expanding the types of information available.

The Governmental Affairs Division has been reorganized under Leo Greenawalt, a lawyer with health care administrative and regulatory experience. The division is responsible for the association's policy analysis, state agency liaison and political action activities. With respect to the latter, the association has doubled its lobbying activities and has formed Friends of Michigan Hospitals — a political action arm similar to MSMS's MDPAC. The key policy functions addressed by this division pertain to patient services, health planning and manpower. Approximately 50% of the MHA's dues support is utilized to fund its Government Affairs Division.

The Association Services Division represents, in staff size and dollar volume, the largest of the Association's Divisions. However, its services are not supported by institutional dues — rather, the institutions pay fees for services received. These services are provided by three departments: the Joint Ventures Department which provides a variety of insurance programs for the majority of hospitals in Michigan including life, weekly indemnity, long term disability, travel accident, tax sheltered annuities, unemployment and workmen's compensation; the Educational Services Department; and the Consulting Services Department which provides a quality assurance consulting service to member hospitals and is developing a financial consulting service.

A major effort this year will be the establishment of the Michigan Hospital Association Mutual Insurance Company to provide professional liability insurance for member hospitals. Hospital insurance premiums on an industry-wide basis increased from 20 million to 70 million dollars during 1975. They are expected to increase another 125% in 1976. It is now not unusual for a hospital to charge $5 per patient day just to cover the cost of such insurance.

The Michigan Hospital Association effort, similar to that of MSMS's effort to provide coverage for physicians, if successful, should reduce such charges by 20 percent. The Michigan Hospital Association continues to work closely with MSMS in seeking legislation which can further resolve the professional liability problem.

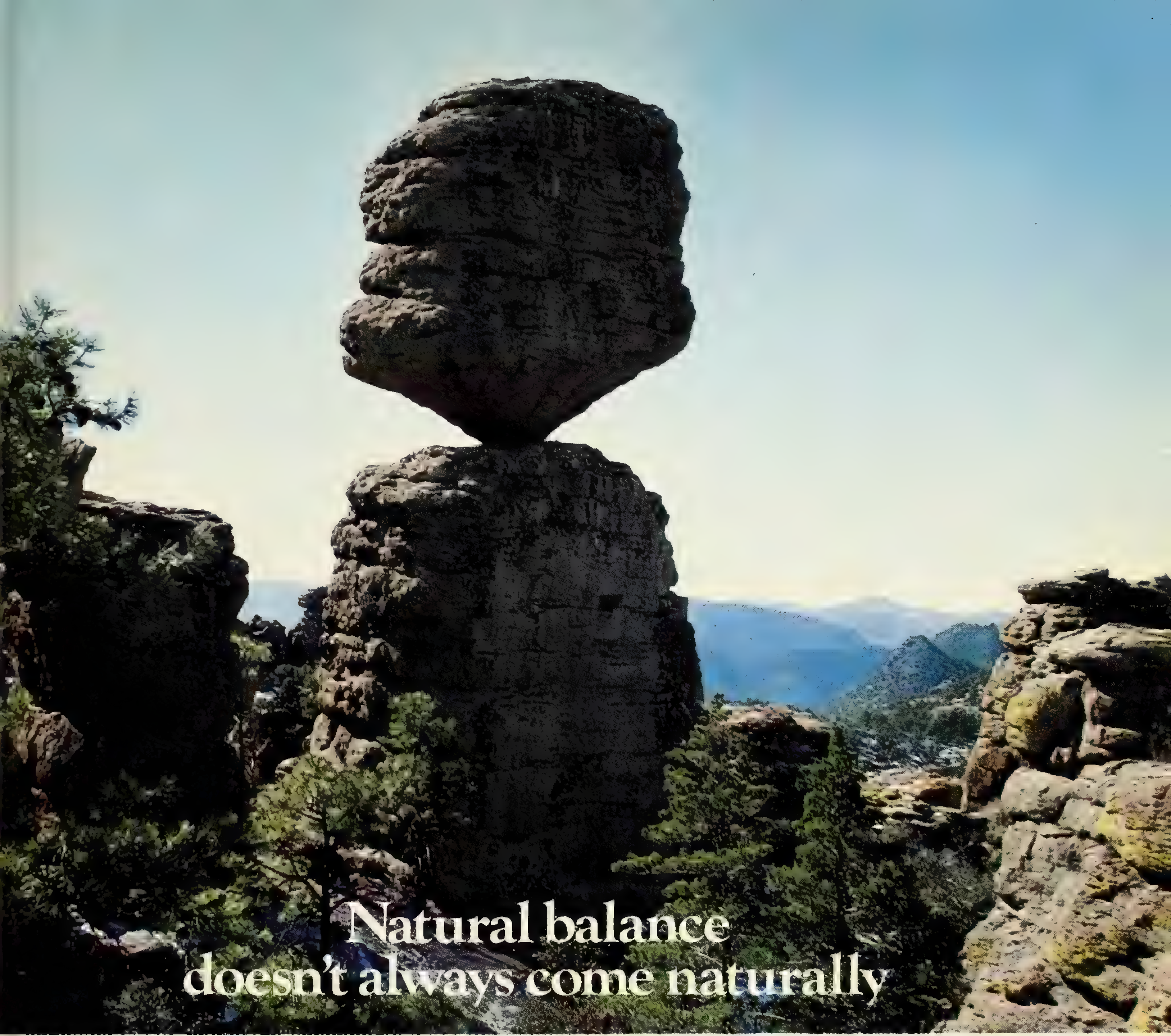
All of the new programs and services developed, or being developed by MHA, are clear reflections of the changing times affecting the health care industry and the vital need for new services, new knowledge and new approaches to old and emerging problems.

Health care professionals must be aware and must be prepared for the ever increasing demands for more service but with stricter regulation; for greater efficiencies but with rising costs and decreasing income.

To meet these problems and many others, and to help increase and develop the capabilities within the health care industry, the Michigan Hospital Association is growing and will continue to grow to meet the needs as articulated by its member hospitals and their patients.

A key element for any success will be a closer working relationship among the major organized provider representatives.

The relationship between the Michigan Hospital Association and the MSMS has been a good one. We hope the reorganized resources of the Michigan Hospital Association can make this partnership a stronger and more effective voice in influencing future health care developments in Michigan.



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Found useful in the management of vertigo* associated with seases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo.*

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Also available as Antivert (meclizine HCl) 12.5 mg. scored blets, for dosage convenience and flexibility.

Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for usea, vomiting and dizziness associated with motion sickness.

IEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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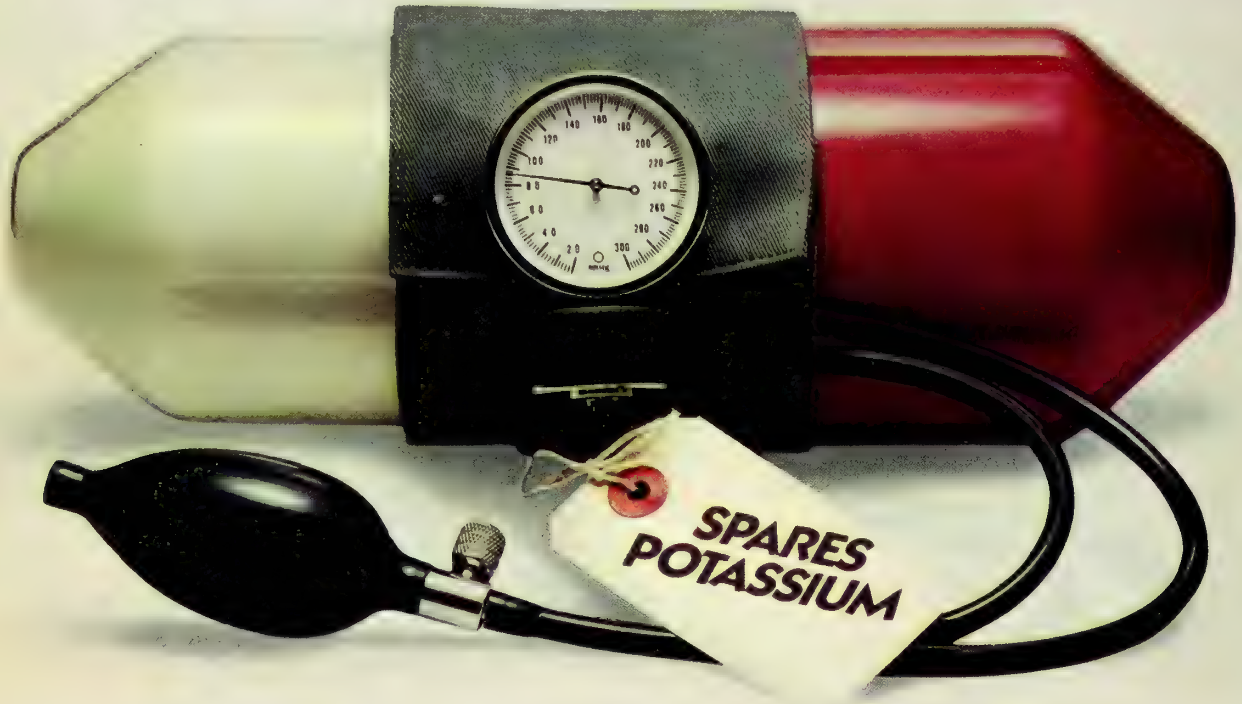

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

> * **Warning**
> This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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Letters

The 'new' Michigan Medicine

I like it! I have always selectively read the journal, and now find myself reading almost all of it.

One suggestion: break out the "meetings" from the "continuing medical education" offerings, and include Osteopathic CME programs. This column could be a real clearinghouse for CME in Michigan, something which is greatly needed. How can the medical schools best get input to you for this?

Ralph E. Lewis
Executive Director
Michigan Medical Schools
Council of Deans

(Editor's note: There is a new feature in Michigan Medicine devoted to Category I CME programs – see page 136 of this issue.)

* * *

Congratulations on a fine effort with *Michigan Medicine*. It is interesting and informative with a general theme that should be of great value to your membership.

Best of luck with the new "Michigan Medicine." You deserve it.

Sincerely,
Robert N. Runyon
Director, Public Affairs
Michigan Hospital Association

* * *

Michigan Medicine is undertaking a new challenge for Michigan physicians.

I think the new format will keep us current on the problems of maintaining a private office, governmental intrusions and economic issues. I congratulate our staff on a change for the better.

Thomas J. Setter, MD
MSMS Publication Committee

I want to compliment you on the excellent appearance and useful content of the January issue of *Michigan Medicine*. The magazine is now truly a timely and useful communicator to the members of MSMS. MSMS has a *real* publication to be proud of.

Roger F. Mecum
Executive Director
Wayne County Medical Society

* * *

I have just read your article in January's *Michigan Medicine* concerning PHSRP recommendations, and found the article very informative. I think the new format of the journal will prove to be very helpful, particularly for those of us who dabble away on the administrative side of things.

Roland G. Hiss, M.D.
Director, Office of
Extramural Education
University of Michigan

* * *

This new journal is more up-to-date and what we need as an organization. I think we've come to realize the medical society is to be our socio-economic arm, rather than medical.

Robert C. Prophater, MD
MSMS Councilor

A proposal for two more committees

In the December 1975 issue of "Michigan Medicine," physicians are requested to serve in a variety of ways, on their own behalf and in the public interest.

1) In an article explaining the new Michigan arbitration law and its effect on physicians, we learn that an eighteen member committee is scheduling regional meetings to educate physicians and hospitals on the provisions of the new arbitration statutes. Presumably, we are expected to attend these meetings and then volunteer for panel duty.

2) Mr. John Richards, of the Michigan State Medical Society staff, calls for physicians to serve as "Doctor of the Week."

3) Elsewhere, physicians are asked to support expanded rural medical care, including serving as preceptors for students assigned to family practice offices throughout the state.

4) The Michigan Department of Public Health calls for physicians to identify Medicaid eligible families with children under the age of 21, so that more children can be enrolled in the "Early and Periodic Screening, Diagnosis and Treatment" program.

5) Jackson State Prison needs physicians to work in the prison infirmary.

Of course, this represents only those items listed in a recent issue of "Michigan Medicine." We are exhorted by the press, our colleagues, hospital administrators and executive staff, and consumer advocates to get involved in helping the public, to educate our patients, to expand our own post-graduate training, and so forth ad infinitum.

My wife and I would like to propose two new committees. Both seem to be in dire need of physicians.

First, there should be a state-wide "Committee for the Care of Patients." Service on this committee would have to be performed at the expense of our other tasks enumerated above, but could help our public image.

The other organization to which we all should belong has been tentatively named by my wife as "The Committee to Encourage Doctors to Spend Time with Their Families." Ideally, this committee should hold daily meetings, but in some cases even bi-weekly attendance would constitute a major advance over the present situation.

Michigan State Medical Society should not appoint any ad hoc study groups to determine the actual need for these committees.

Sincerely,
Mark C. Levine, M.D.

About the new 'no smoking' signs

(Available on request from MSMS)

Dear Fellow Health Professionals:

I offer you a golden opportunity to join with your public health colleagues in practicing the highest form of preventive medicine. Here you can influence your community (patients and their associates) in a most significant fashion. Encouragement by you in stopping smoking cannot be overestimated.

Cordially,

Maurice S. Reizen, MD
Director, Michigan
Department of Public Health

* * *

When I was young, most men chewed tobacco, as evidenced by the brown cuds that dotted the snow banks on winter days. We didn't have white Christmases; they were brown and white.

Today almost no one chews. It wasn't that the Surgeon General admonished danger from the signs on the sides of barns but rather that a tuberculosis campaign against public spitting made people sensitive to what a disgusting habit it was: Public disapproval is the strongest modifier of behavior.

Now we must put a stop to cigarette smoking. Since appeals to reason and to law have not availed, we must heed the lessons of chewing tobacco and mobilize public disapproval. In this we are aided by studies which indicate that second-hand tobacco smoke may be damaging to non-smokers even as second-hand chewing tobacco helped to spread tuberculosis.

To that end, the two-thirds of us who are non-smokers must show visible distaste for the smoky exhalations of the other third; we must post signs such as those provided in the November issue of *Michigan Medicine* ("Caution! Your smoking is hazardous to my health"), and relentlessly reduce the areas where smoking is permitted until the very last practitioners of this unhealthy habit are figuratively and literally left standing in the corner. Come, let us pick on smokers: It's a good, healthy sport, for them and for us.

Richard C. Bates, MD

* * *

Let me urge all whose eyes fall upon these lines to place the sign, "Caution! Your smoking is hazardous to my health," in offices, examining rooms and waiting areas. Let's post it too in many and diverse public places, not forgetting schools and hospitals. The sign is plea and pressure . . . yours and mine . . . for no smoky patients, physicians, parents, nor the puerile, maturescent and patriarchal. We'll make it longer with fewer itchy eyes, less tearing, blowing, coughing, wheezing.

Ezra V. Bridge, MD
President
Michigan Lung Association

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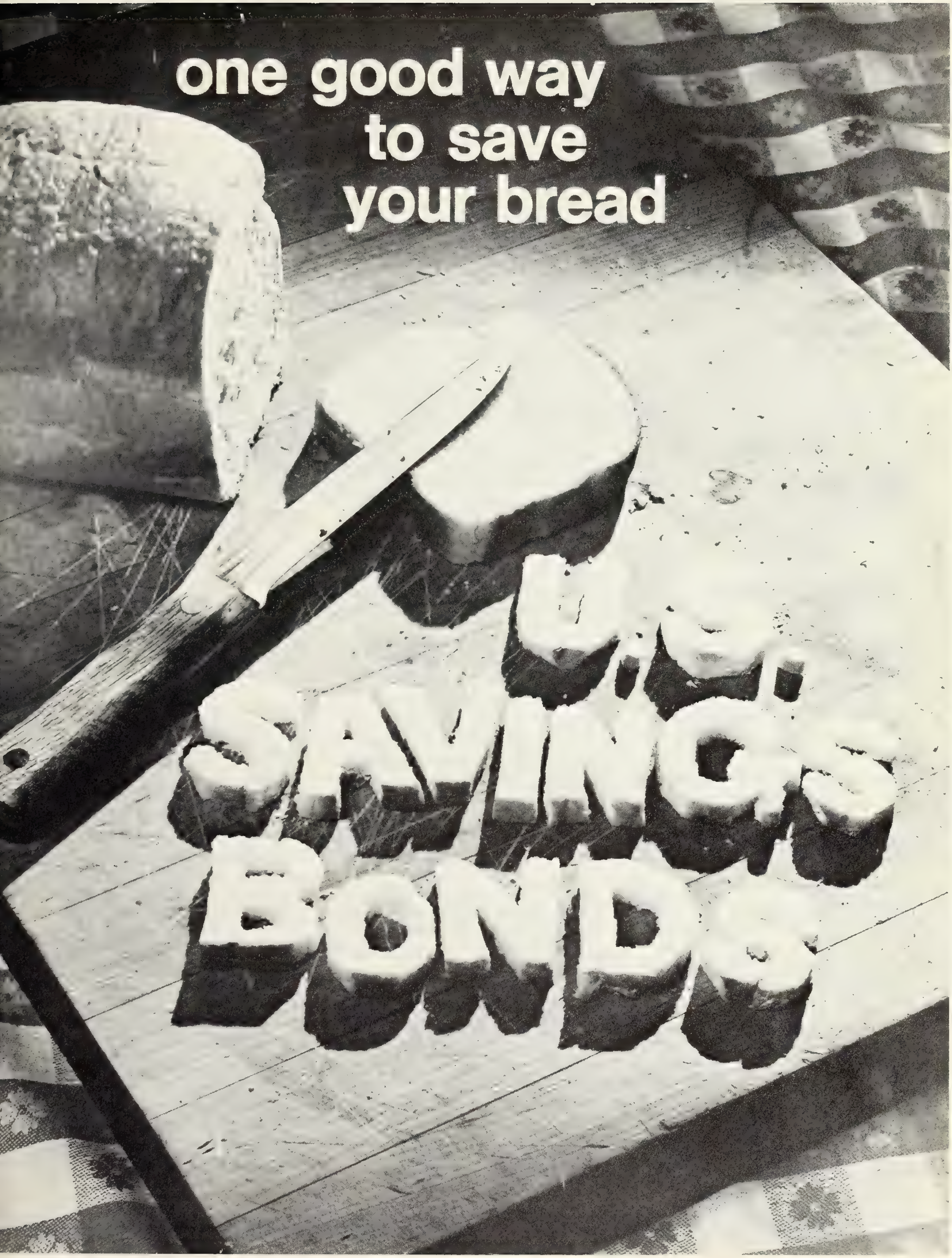
one good way
to save
your bread
U.S.
SAVINGS
BONDS

PROFESSIONAL MANAGEMENT

Should you incorporate? Here's what to consider:

By John Anthony, Chief, and Donna Allen
MSMS Bureau of Economic Information

Over the last few years, there has been a tremendous number of physicians who have incorporated their practices. This trend has developed because of cost effective and tax saving benefits. Virtually all physicians who have made the switch to an incorporated practice have been satisfied.

The real advantages of a PC are the insurance and retirement programs from which you, as an employee of the PC can benefit.

The benefits

As a non-incorporated physician, you pay several hundred after-tax dollars a year on a health care insurance plan. But this is an allowable expenditure for a corporation and, consequently, is deducted from revenues, along with other expenses, to determine corporation profits.

PCs may have disability or wage continuation plans as fringe benefits for employees. They are a good vehicle for continuing the wages of a physician who has suffered a disability or illness. The premium for these programs is tax deductible for a PC.

Another significant savings generated by a PC is the premium cost of group term life insurance. The premium for a policy worth up to $50,000 for each physician in the corporation is a legitimate cost of the PC.

Probably the major benefit of a PC is the possibility of varied and flexible pension and profit sharing provisions. The wide range of investments under the tax sheltered plan gives more flexibility than Koegh programs. With a PC, it is possible for an MD to retire at any age. Also, corporations have a greater range of vesting privileges. Death benefits in a PC are not subject to a tax.

PCs, with their limited liability, provide an excellent tax rate from which to make capital improvements. The updating of estate plans, from one year to the next, is easily facilitated with a PC. Retirement is also an easy process.

PCs may be beneficial in recruiting physicians to join a group practice. Miscellaneous business expenses are better recovered in a corporation. Ancillary employees tend to be happier working for a PC because they also share in the expanded fringe benefit program.

The expenses

There are initial and ongoing expenses to consider when deciding whether or not to incorporate. To establish a PC, the physician should expect legal and accounting fees of about $2,000. These fees, of course, will differ greatly according to the complexity of the PC. Annual accounting and legal costs can range between $1,300 and $2,500. Workmen's compensation insurance costs $75/year for each physician. Pension and profit sharing costs are approximately $300 to $400 per year.

The major cost consideration of whether to incorporate is the 20% surcharge most professional liability insurance companies are charging physicians for the coverage of their PCs. This can amount to over $2,000 each year.

Other considerations

Since the Keogh plan has been expanded to allow greater tax sheltering amounts ($7,500/year), the decision to incorporate has been greatly clouded. Before the recent change in the law, the advantages of a PC far outweighed their costs. However, now with the greater range in Keogh, and with the 20% surcharge for professional liability insurance, the decision becomes a hard one.

Physicians should meet with the proper accounting and legal consultants and decide if the cost benefits and retirement provisions of a PC should be obtained. Each physician should go through an analysis of his professional format. The proper form of business can provide thousands of dollars in extra income and other benefits.

Nothing Changes

"The cost of practicing medicine today is definitely greater than 60 years ago. Such items as rent, particularly in the cities of larger population, are out of all proportion to rents of those days. The cost of medical education today or any time during the past quarter of a century is greater and the time spent in premedical and professional training is likewise much longer.

"All factors considered, the cost of medical service is today actually less so far as the doctor's part in it is concerned, than 60 years ago. A great many physicians have not advanced their fees during the period of general price inflation during and following the war, in spite of the fact that the overhead has practically doubled, particularly in such laboratory specialties, for example, as roentgenology and clinical laboratory work."

—Excerpted from MSMS Journal
Editorial, August 1930

Answering some oft-asked questions about arbitration

The questions are coming thick and fast from physicians as Michigan's new arbitration system goes into effect as an alternative to courtroom litigation of professional liability suits. The following article attempts to answer some of the frequently-asked questions, most of them about arbitration in the hospital setting. A brief analysis of the 1975 laws establishing the arbitration system and their requirements for physicians has just been published in the Feb. 20 issue of the MSMS *Medigram* newsletter. This article was prepared by MSMS staff and legal counsel.

Q. What does the law require of independent medical staff members in the hospital setting?

A. A valid hospital agreement binds the hospital, all its employees and those of its independent hospital staff who have agreed to arbitrate. The physician is involved in the following ways:

A. The independent medical staff will be asked to participate in the hospital arbitration program to achieve required participation levels.

B. The Insurance Commissioner has approved an independent health care provider and hospital arbitration agreement form. By signing this form the independent health care provider is agreeing to arbitrate with patients (who sign the Hospital Arbitration Form) any disputes arising out of care rendered by him in the hospital during the course of inpatient, outpatient or emergency room care. The independent staff member is also agreeing to arbitrate with the hospital any disputes concerning their respective liability to the patient. This agreement is valid for one year and is automatically renewed unless the doctor withdraws, in writing, at least thirty (30) days prior to the annual renewal date.

C. At the end of the first year of implementation, independent providers responsible for treating or admitting 75% of the institution's patients must have agreed to participate in the arbitration program. The participation level moves to 85% in the second year and to 90% in the third year. Failure to achieve participation levels could result in an institution's loss of medical malpractice insurance and punitive action by the state.

Q. Is participation in the in-hospital agreement a complicated affair?

A. No. The law has made it extremely easy for the doctor to participate in the hospital setting. He has only to sign the arbitration agreement once in his lifetime. Unless he revokes it, the agreement is renewed every year. The one agreement he signs is good also no matter how many physicians are involved in care of each patient. This is a simple system for covering in-hospital care, from which an estimated 90% of suits arise.

Q. How well is the arbitration system being received by patients across the state?

A. Some hospitals have reported 80% participation of patients, while others lag far behind. Much seems to depend on how aware hospital personnel are of the arbitration system and its significance, and how attuned they are to presenting it to patients who may have questions.

Q. Must I care for patients who won't sign the arbitration agreement?

A. The law clearly states that refusal to sign an arbitration agreement cannot be used to deny medical service.

Q. Will the arbitration procedure be an effective cost-saving process?

A. Only time will tell. Michigan's law was proposed and passed because experiences with arbitration systems in non-medical disputes proved that costs often were saved.

Q. Are emergency patients required to sign the arbitration agreement, and if so, when?

A. Emergency patients must be offered the arbitration agreement, but must not sign until after their emergency care or treatment is completed. Definition of "emergency" will probably come in due time.

Q. Does the hospital arbitration agreement cover after-care in the doctor's office?

A. No. If the follow-up treatments in the doctor's office are covered, they must be covered separately by a doctor-patient agreement form.

Q. Does the arbitration procedure negate the protection by law of juveniles treated in the emergency room, as, for example, with cases of VD?

A. No. Arbitration is procedural; it has not changed the substantive law.

Q. Should I offer the arbitration agreements to patients in my office?

A. Yes. There are benefits for both the patient and doctor. If disputes arise out of office care, there could be benefits to both in having the dispute arbitrated rather than going before a jury. Some of these benefits could include (1) savings in time; (2) savings in money; (3) the arbitration panel may prove to be more objective and less swayed by emotion; (4) the

(Continued on page 164)

National Health Insurance: It's still not what but when

By Robert E. Rice, MD
Chairman, MSMS Committee on Federal Legislation

A panel of Washington, D.C., governmental authorities appeared recently at the AMA Leadership Conference in Chicago, and in one 20-second interval provided perhaps the best background yet to national health insurance legislation.

The panel was asked to write down the number of months they believe will lapse before a national health insurance bill emerges that has any chance of success. Not knowing what their fellow panelists were guessing, the four responded: Two said 60 months; one said 40 months; one said 30 months.

Thus lies the uneasy future of national health insurance.

No one disagreed that after the 1976 election there will begin to be serious progress toward NHI legislation.

No one disagreed that during the 1976 election year there will be sound and fury over NHI.

All agreed that the parties to eventual negotiations toward national health insurance are so far separated that any chance of success in the next two and a half years, at the earliest, is moot.

More than a dozen NHI bills were introduced in the last (93rd) Congress. Many of these, some with modifications, have been reintroduced in the current (94th) Congress. However, the President's budget proposals significantly backed off from his earlier support of a national health insurance plan by offering in its place a $538 million catastrophic care package to the nation's 24 million Medicare eligibles.

Three Types of NHI Proposals

Of the major plans under discussion, many would continue and expand the concept of health care furnished through employee group insurance. Since under these plans

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most persons are covered through insurance offered to employees (and their families) and financed entirely by employer and employee, any need for government financing and additional taxes is limited. These plans also provide coverage for those who are unemployed, self-employed or unable to meet the cost of health care insurance. Comprehensive coverage would be available to them (as to the employed population), and the government would share the cost. Any government cost would be paid through general revenues and without special taxes.

Of the various employment-based insurance plans, all but one would require an employer to provide such insurance for employees. This principle is employed in the current AMA plan (HR 6222); and the American Hospital Association plan (HR 1); and the U.S. Chamber of Commerce plan (S 2644); it was also one of the principles of the Administration plan (S 2970, 93rd Congress). The current Health Insurance Association of America plan (HR 5900), while advocating employment-based insurance, departs from the principle of required employer participation. Unless coverage provided by an employer meets the program requirements of that plan, however, the employer stands to lose the benefit of income tax deductions for premiums paid. Employers will pay at least 65% of the premium under the AMA plan, 75% under the AHA plan, and 50% under the Chamber plan; no minimum requirement is provided in the HIAA plan.

Another bill, the Kennedy-Corman plan (S 3, HR 21), has marked similarities to the British system. It establishes a national health service rather than private insurance coverage. Health care would be provided within a fixed national budget annually established by the federal government. Funds would be created through new social security taxes levied on payroll, wages, and self-employment income for one-half of the cost and through general revenues for the remainder. (For example, of $100 billion of national health insurance costs, $50 billion would have to be raised through new social security taxes.) These funds would be divided among regions throughout the country and then allocated to health service areas within each region. All participating physicians and providers would be under contract to the federal government. As a principal form of coverage, through capitation, individuals and families would enroll in a prepaid group practice or with a primary physician for a year at a time. Those

AMA Supports HR 6222

This is a reminder to physicians that the AMA is supporting HR 6222, calling for a comprehensive health care insurance program, as its approach to national health insurance issue.

HR 6222 is described by AMA President Max H. Parrott, MD, "as a plan which can be financed in the private sector with a minimum of federal support." The AMA is on record opposing the public utility approach to health care delivery as proposed in HR 1.

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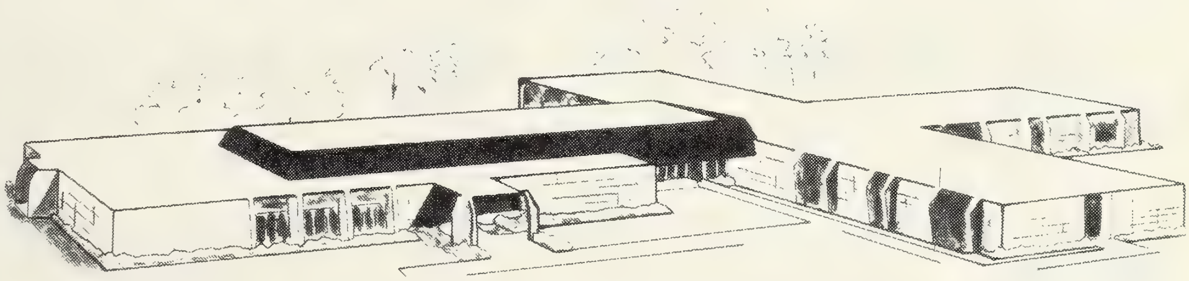

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NHI/*Continued*

on the rolls of a primary physician would have all of their care provided (within a stated schedule of benefits) by the primary physician; they would have the services of specialists only on referral by the primary physician.

A third form of national health insurance would provide only for "catastrophic" coverage. Benefits would begin after certain health care expenses were incurred by the individual or family. (The individual or family could purchase insurance to meet basic health care expenses.) The Long-Ribicoff catastrophic insurance bill (S 2470) would establish separate deductibles for hospital expenses of 60 days and for medical expenses of $2,000. Financing of the catastrophic insurance plan would be provided by a 1% payroll tax on employers, with an offsetting tax credit to the employer of 50% of such tax. An option contained in the new proposal, however, would permit the employer to purchase equivalent catastrophic insurance from a private insurance company, and such private insurance would be administered by the private carrier. As a separate program, the proposal would provide for basic coverage to low-income persons and families financed through general revenues. The Social Security Administration would administer the public portion of the catastrophic coverage program and the program for the poor in parallel with Medicare.

Obviously, there is a great deal of coming together necessary before any plan gathers a majority of votes in Congress.

ARBITRATION/*Continued*

arbitration panel can decide to recompense the plaintiff with remedial care as well as, or other than, money.

Q. Are all PCs covered equally well when a member of the PC signs an agreement?

A. The PC is covered if the PC signs, and its employees are thereby bound as to all services performed as PC members. (Not so, however, if the doctor has also a distinctly separate practice in another capacity or is perhaps "moonlighting.")

Q. How are arbitrators selected?

A. Cases are to be heard by a panel of three arbitrators: (1) an attorney to serve as chairman; (2) a physician, preferably from the same specialty as the respondent, and (3) one lay member. Panel members will be selected by the parties to the dispute from lists of five persons sent by the American Arbitration Association. Each party has the opportunity to list its choices in order and the arbitration association will then invite those chosen to serve. There are provisions for deadlock situations.

Q. If I am interested, how do I apply to be an arbitrator?

A. Criteria to qualify as an arbitrator now are being developed by the Michigan Arbitration Advisory Committee to the insurance commissioner. At present, you may write to the American Arbitration Association, City National Bank Building, Detroit 48226.

Q. Does arbitration always result in an award for the patient?

A. No. Arbitration is not mediation. The arbitration panel, just as the courtroom jury, is charged with the responsibility for finding for either the plaintiff or the respondent. In addition, if it is determined by the panel that the case is without basis, it can assess the charges accordingly.

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In Memoriam

Vinton A. Bacon, MD
Detroit

Vinton Arthur Bacon, MD, Detroit family physician, died Dec. 11 at the age of 81. Doctor Bacon was a graduate of Rush Medical College and was a life member of the Wayne County and state medical societies. He was affiliated with Brent and Lincoln hospitals of Detroit.

Edward G. Bauer, MD
Waterford

Edward George Bauer, MD, Pontiac-area general surgeon, died Dec. 30 at the age of 62. Doctor Bauer was a graduate of the University of Michigan Medical School and was affiliated with Pontiac General Hospital.

Roland E. Berry, MD
Escanaba

Roland E. Berry, MD, past president of the Delta-Schoolcraft Medical Society, died Jan. 15 at the age of 55. Doctor Berry was former director of laboratories at Iron Mountain VA Hospital and St. Francis Hospital, Escanaba. He was a native of Maine and graduate of Tufts University School of Medicine. He came to Michigan in 1961 after serving on the faculties of Harvard and Tufts medical schools.

George M. Brown, MD
Bay City

Past president of the Bay County Medical Society, George Maxwell Brown, MD, died Dec. 26 at the age of 80. Doctor Brown was past president of the Bay County Crippled Children's Society and member of the staffs of Bay Medical Center and Samaritan Hospital. A graduate of the University of Michigan Medical School, he was associate fellow of the American Proctologic Society and past president of the Michigan Proctologic Society.

Gilbert L. Edwards, MD
Detroit

Detroit physician Gilbert L. Edwards, MD, died Jan. 4 at the age of 70. He had practiced 35 years and was on the staff of the Boulevard General Hospital. He was a life member of the NAACP.

Thomas E. Fleschner, MD
St. Petersburg, Fla.

Former Birch Run family physician, Thomas Elmer Fleschner, MD, died Jan. 15 at the age of 70. He moved to Florida in 1970 after serving Birch Run for 31 years. He was a graduate of the Wayne State University College of Medicine and was a charter member of the American Academy of Family Physicians. He was affiliated with St. Mary's Hospital, Saginaw.

Harold H. Heuser, MD
Bay City

Harold H. Heuser, MD, 72, died Dec. 27. He was a long-time ophthalmalogic surgeon and active in the American Association for the Prevention of Blindness. A graduate of the Northwestern University Medical School, he had practiced in Louisville, Ky., before coming to Bay City. He was board certified and a member of the International College of Surgeons. He was former chief of staff at Bay City Mercy Hospital.

William E. Miller, MD
Detroit

William Ernest Miller, MD, family physician and medical director for the Life Insurance Co. of Virginia before his retirement in 1972, died Jan. 30 at the age of 89. Doctor Miller was a graduate of the Detroit College of Medicine and was in practice 50 years.

Bernard Patmos, MD
Adrian

Former Bixby Hospital, Adrian, chief of staff, Bernard Patmos, MD, died Jan. 7 at the age of 70. Doctor Patmos had been on the Bixby staff since 1933 and was active in civic affairs. He was past president of the Lenawee County Medical Society.

* * *

Clarification: William LeRoy Harrigan, MD, whose obituary was printed in the January issue of *Michigan Medicine*, was a family physician, rather than an obstetrician-gynecologist, as reported in that issue. He was not affiliated with Midland Hospital.

MSMS jail health project underway

Four county jail systems have been selected by MSMS for study in the new MSMS pilot program to improve medical care and health services in jails. The program was granted $25,000 by the AMA on Jan. 5.

Robert E. Medlar, MD, Jackson, is newly-named medical director of the pilot program, and physicians in each of the four counties are being named as local coordinators. The jails are in Lake, Oakland, Shiawassee and Washtenaw counties.

Representatives of Blackstone Associates research consultants of Chicago were in Michigan late in February to complete initial survey plans and visit some of the jails to be studied.

MSMS was one of six state medical societies selected from 30 which applied for the AMA grants, initiated with an endowment to the AMA from the Law Enforcement Assistance Association.

The MSMS project has been endorsed by the Michigan Department of Corrections and the Michigan Sheriffs' Association.

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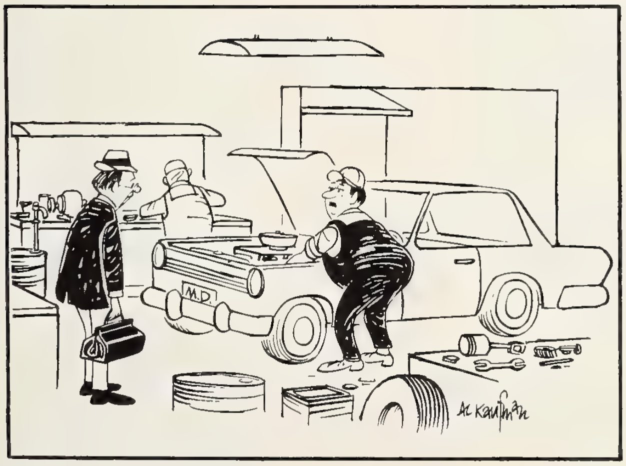

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POTPOURRI

By Herbert Auer, Executive Editor

A recent issue of *Michigan Hospitals* contained an article about the inroads that government is making in the health care field with the provocative headline, "Caution: Government Can be Hazardous to Your Health." The Michigan Hospital Association journal carried a byline article by M. Stanton Evans, former editor of the *Indianapolis News* and a regular contributor to *Private Practice.* He contended that "We confront a round-robin of government-generated answers to government-created problems — answers that are or very shortly will become considerable problems in themselves."

* * *

Physicians, especially ophthalmologists, have opportunities to assist local Child Study Clubs this year in the Michigan-wide study unit on "Vision Problems of Pre-Schoolers." MSMS has provided educational materials to the Michigan Child Study Association for this health education project.

* * *

One of the state senators enjoys making this observation — "I'm always amused when I realize that physicians, attorneys and great insurance companies want me — a $19,000-man — to solve the professional liability problems."

* * *

At a recent Component Leadership Conference, sponsored by MSMS, Thomas C. Payne, MD, Lansing, led a workshop of officers from larger components, and Robert E. Rice, MD, Greenville, presided at the discussion among the leaders of smaller components. Many suggestions were made to strengthen MSMS components. Among the suggestions were: (1) Send component bulletins to the physicians' home addresses so the spouses could read the newsletters and thus hopefully stimulate discussion at home, (2) Open the component society meeting program with the business and speaker first and then have drinks and dinner; rather than close with the society business involving only a handful of the loyal members who remain.

* * *

When we make an error in *Michigan Medicine* — and most often the misspelled word forms another word — I always remember the classic that involved Franklin Delano Roosevelt. One morning the telephone rang at the *Washington Post* and the voice said, "This is President Roosevelt. Would you send over to the White House 10 copies of yesterday's Post." The reporter was curious so he scanned the headlines to discover the classic headline typo: "President in Bed with Coed."

* * *

To help set right the critics of medical care in the USA, physicians should drop this line into conversations at meetings: "Did you know that the U.S. infant mortality rate for the first eight months of 1975 was 3% less than for the same period a year ago?"

* * *

Comedian Sam Levenson asks, "If medicine has made so much progress in 50 years, how come I felt better 50 years ago?"

* * *

Michigan Medicine will strive hard to meet a new challenge with our new format and different content. There is a feeling in the nation today that newspapers and magazines do a good job of reporting on meetings and projects, but they do a poor job of reporting on ideas. That challenge is voiced by John R. Murphy, publisher of the *San Francisco Examiner* and formerly of the *Atlantic Constitution.* He observes that TV tends only to cover hard, breaking news, and cannot move into the "ideas and issues area" as easily as the media using the printed word.

One year from now, your *Michigan Medicine* staff will evaluate itself on how effectively your monthly journal is dealing with issues, concerns and problems, facing the medical profession and the medical organizations.

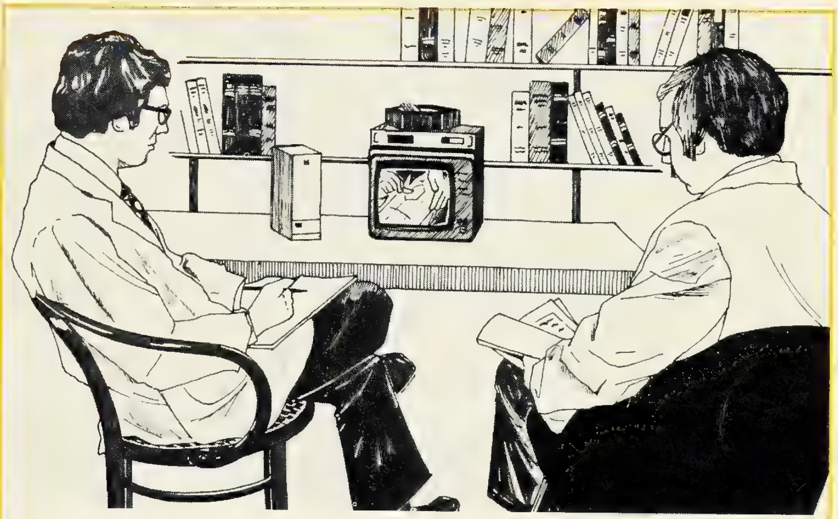
* * *

A suggestion was made that directors of medical education complete 50 hours each year in accredited courses of education at the recent AMA Congress on Medical Education by George E. Miller, MD, director, Center for Educational Development, University of Illinois College of Medicine. He urged the Association for Hospital Medical Education to work with other associations "to spell out the components of competence required to fulfill the responsibility of program planning and implementation and to develop a mechanism for certification of that competence based on exhibited proficiency."

Michigan doctors discuss a person's right to die as he wishes, in two special articles beginning on page 208. Do you share their viewpoints?

MICHIGAN MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 4 APRIL 1976



gan doctors in community hospitals and outstate areas have
: opportunity to earn continuing medical education credits
gh the University of Michigan's Media Library. How to use
jinning page 178.

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MAY 5 1976

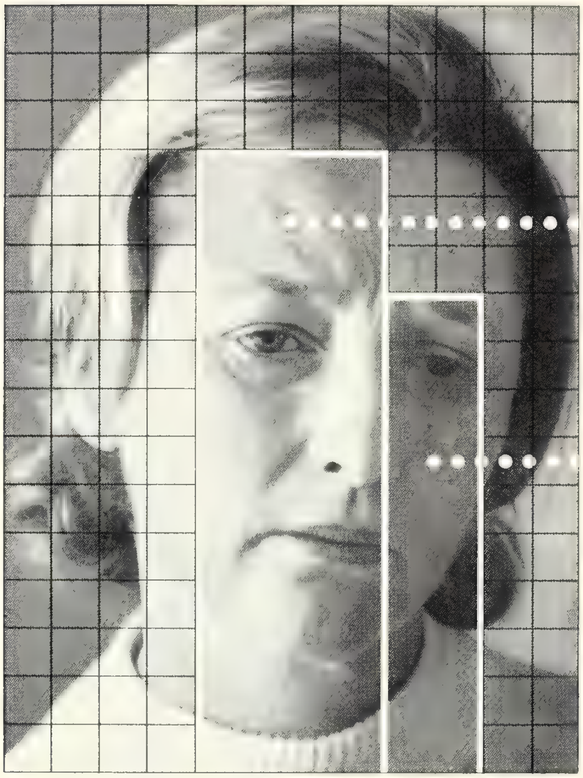
Robert M. Leitch, MD
to be installed May 1
as 1976 MSMS president

Michigan doctors must face the fact that their skills will be assessed on a regular basis. Six studies are underway now in Michigan to regulate professionals through relicensure. MSMS views of recent relicensing actions taken by the State Health Planning Advisory Council are on pages 224-225.

What will your MSMS delegates be doing April 30 — May 2 in Troy during the MSMS Annual Session? Details on pages 190 and 192.

Also inside: Report on a statewide SIDS autopsy program, new Maternal Health Desk Reference card, Doctor Brush assesses the current professional liability insurance situation, improving office efficiency.

Both often



Predominant psychoneurotic anxiety

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the Next Issue

Michigan blooms in May:* Michigan Medicine *will blossom with a group of special articles by state leaders in government, education and medicine. They will discuss Michigan's medical picture today as they see it.

Also planned are a report on the Medical Practice Board's activities, features on continuing medical education and updates on the MPMLC and MSMS's jail survey.

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PRESIDENT'S PAGE

As I see it

Michigan's physician insurance picture today

Brock E. Brush, MD,
MSMS President

In this, my final President's Page, I would like to thank the members of the society for the privilege and honor of being their chief for the past year. I believe this year will be recorded as the most tumultuous in the history of our MSMS.

In the year before I became president the professional liability crisis came crashing down upon us. While it will obviously take another year or two for this problem to be alleviated, we have gotten well along on some of the solutions. With good cooperation between physicians, lawyers, legislators, labor groups and other concerned citizens, as well as Governor Milliken, the MSMS has succeeded in getting 13 of our original 16 proposed legislative bills passed. Yet there is much more to do legislatively. Our committees are continuing to work to improve the legislative package toward making Michigan one of the best states in the nation in regards to remedies for the malpractice blight.

In spite of this great effort, which amounts to tens of thousands of hours devoted by staff and physicians on our various committees, many doctors still stop me to ask "why the Michigan State Medical Society is not doing more to solve the insurance problem *immediately*." I continue to get criticism from both ends of the spectrum, and vested interest groups, each with suggestions which are mostly unreasonable and impractical at this time. It has been my continued position that strikes and work stoppages are not the answer for us at this time. I have also received many suggestions from the Class V group suggesting that all physicians in Michigan help them pay for their high malpractice rates. Of course, the opposite viewpoint is held by those Class I's who state that they cannot and will not be forced to pay some other physician's malpractice costs without also sharing in some of his income. MSMS obviously cannot accommodate all divergent views.

The problem is that we are influenced by the "now generation," which demands a lot of action immediately, sometimes drastic, militant and radical, to ease this unfortunate burden on all physicians. I feel that never before has mature, sensible judgment been needed more in looking at the total picture, including our public image and the probable results of some hasty actions which have been suggested.

The insurance problem is, of course, divided into two phases: (1) **availability**, and (2) **cost**. The state's temporary Brown-McNeely fund has provided insurance to all those physicians who cannot otherwise obtain it. In this respect I think it has been of great service to the doctors of Michigan. The Brown-McNeely Fund, its board members Odessa Comer, Harvey Gass, MD, and myself, with great assistance from Insurance Commissioner Tom Jones and Mr. Robert Rowe, have worked sincerely and honestly to develop a high-class, well-run, responsible fund with a competent carrier, with aid

(Continued on page 176)

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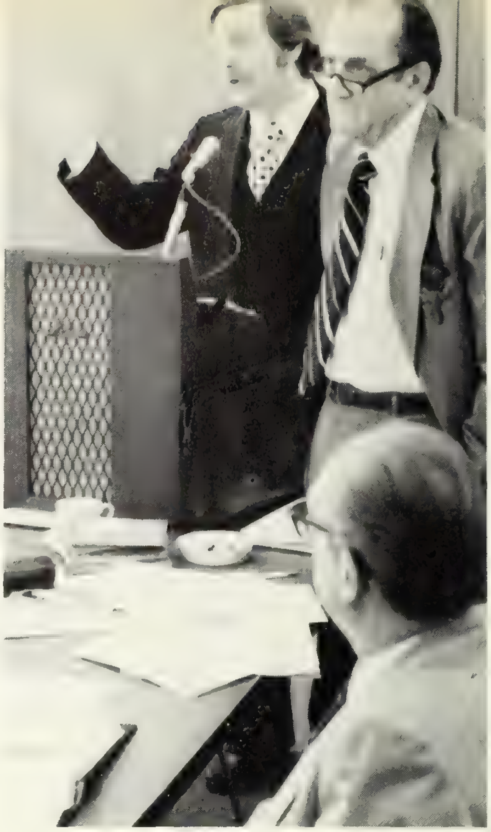
William Cheeseman, insurance administrator for the MPMLC, addresses the board.

The long, tireless efforts of MSMS leaders, staff and advisors to form a professional liability company for MSMS members have been led by the persons photographed here during a recent board meeting of the Michigan Physicians Mutual Liability Company. For nine months, they have hammered out the company's corporate structure, met intricate requirements for governmental approval and developed strategy for promoting the MPMLC. Now, with nearly a year's efforts behind them, they stand ready to issue their first policies to MSMS members.



Fine points are interpreted for the board by Mr. Cheeseman, left, and MPMLC President Vernon V. Bass, MD, Saginaw.

Board members above include Kenneth J. Ray, MD, Grosse Ile, left, and Robert E. Rice, MD, center.

On the board, from top, are Louis E. Heideman, MD, Detroit (dark glasses); Donald N. Sweeny, Jr., MD, Detroit; Ernest P. Griffin, Jr., MD, Flint, and Robert M. Leitch, MD, Battle Creek, back to camera.

FAMILY PRACTICE RESIDENCY PROGRAMS IN MICHIGAN

CITY – HOSPITAL	YEAR PROG. BEGAN	NUMBER IN TRAINING	NUMBER OF NEW RESIDENTS AS OF 7/1/75	NUMBER WHO FINISHED TRAINING IN 1975	NUMBER WHO WILL FINISH TRAINING IN 1976	PLANS OF THOSE WHO FINISH IN 1976
Dearborn — Oakwood Hospital	1971	14	5	2	3	Two will practice in Dearborn; one is undecided.
Detroit — Bon Secours Hospital	1975	3	3	0	0	—
Detroit — Grace Hospital	1975	4	2 (2 more as of 10/1/75)	0	0	—
Detroit — St. John Hospital	1974	5	4	0	0	—
Flint — St. Joseph Hospital	1971	21	11 (5 more as of 1/1/76)	1	3	Two will practice in Flint; one is undecided.
Grand Rapids — St. Mary's Hospital (GRAMEC)	1973	19	8	1	4	None have decided.
Lansing — Sparrow Hospital	1970	18	6	6	4	None have decided.
Midland — Midland Hospital Center	1968	18	6	5	7	Six will practice in Michigan (two in the U.P.); one in Calif.
Saginaw — Saginaw Cooperative Hospitals	1968	18	7	1	6	Two will practice in Saginaw; two in Ludington; one in West Virginia (Nat. Health Service Corps); one is undecided.
		120	59	16	27	

Kalamazoo has not, as yet, begun its family practice residency program, but hopes to have one started by July, 1976.

MSMS Bureau of Economic Information

How do you benefit as an MSMS member?

– You, your family and friends may take advantage of MSMS's excellent, physician-oriented travel tours.

Mexico City, Copenhagen, Rome — they're yours in the 1976 selection of MSMS-sponsored medical seminar-travel tours entitled "Mayan Adventure, Viking Adventure," and "Mediterranean Adventure."

The package tours include transportation, accommodations, guides, side trips, and some meals, in various combinations. They are arranged for MSMS this year by INTRAV, which specializes in trips for physicians, dentists and other professionals and keeps their particular preferences in mind. The tours are unregimented for maximum individual travel freedom.

INTRAV, as do all MSMS seminar-travel sponsors, meets rigid MSMS specifications for financial soundness, experience, reputation, interest in physicians and their particular needs and ability to produce meaningful and interesting medical seminars.

INTRAV is the only official travel agent for MSMS in 1976, and is not to be mistaken for the myriad of other companies inundating MSMS members with travel information and even using the MSMS name on mailings. INTRAV serves 35 similar professional organizations.

MSMS has been offering travel-study tours sine 1970, and each year reviews interested companies before deciding on its official travel agent. The trips are held to a maximum of three each year by MSMS to ensure full plane-loads each time.

This year, for the first time, the trips have been opened to friends of MSMS members. In the past they were restricted to persons affiliated with health organizations.

Physicians wishing further information on 1976 MSMS travel-study seminars may contact Mrs. Marcelyn Ireland at MSMS headquarters.

DOCTOR BRUSH/*Cont.*

from the attorney general's office and the state treasurer's office. We have kept the insurance rates within the limits recommended by three actuarial consultants and have consistently acted responsibly in these areas. We do regret that the rates for the time being, continue high and we all hope that they will soon be less. However, these rates just cannot be wished away. They must be lowered by a continuous, consolidated effort by all MSMS members.

When the Michigan Physicians Mutual Liability Company becomes operational in the near future, the Fund will turn over to it a responsible, ethical, and well-begun organization with a great deal of expertise and much of the leg-work well started. We *must* have the MPMLC. I have consistently and persistently urged all Michigan physicians to support our own company for the many, many improvements which it will provide.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** * **Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Methionine	12 mg
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Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

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ACTION AND USES DOSAGE: 1 tablet after breakfast and supper or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets.

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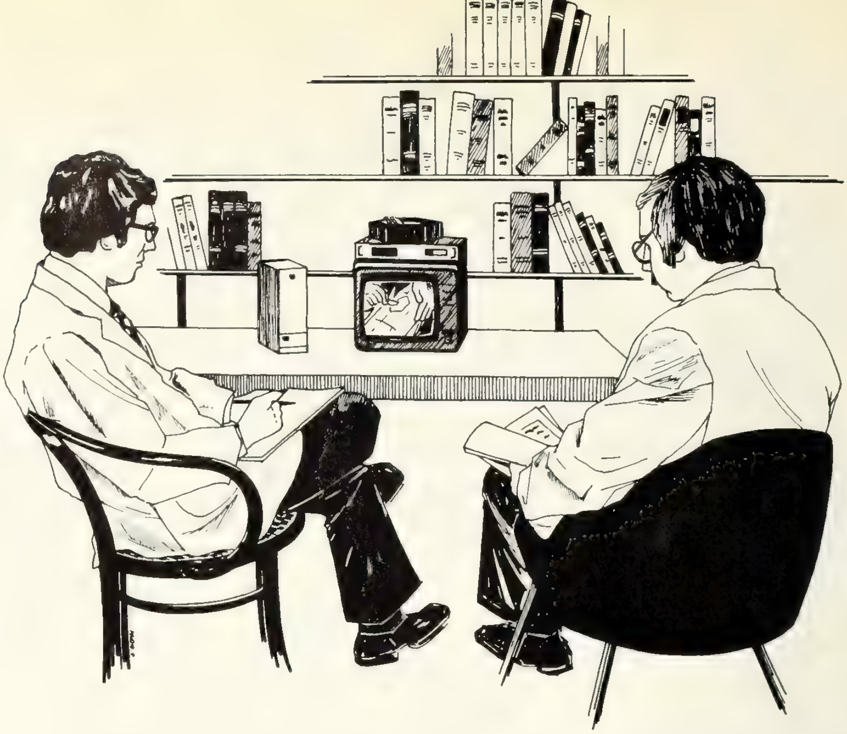

How the U of M Media Library can help you earn CME credits

By Robert K. Richards, PhD, Roland G. Hiss, MD, Bruce A. Work, Jr., MD, and George A. Dean, MD

Ann Arbor

Media Library, an innovative effort to use slide-sound study programs in hospital-based CME, has been developed over the past six years by the University of Michigan's Department of Postgraduate Medicine and Health Professions Education. Use of Media Library programs in staff educational meetings or in individual study will allow physicians to earn CME credit in their own local hospital. Smaller hospitals planning hospital-based CME programs encounter special problems due to the limited learning resources available. The evolution of Media Library to assist in improving the resources available in these hospitals is described. Current experiences in working with local hospital staffs are outlined as well as the future goal of making Media Library an interactive continuing affiliation between a medical school and hospital staff.

Media Library, an innovative approach to hospital-based learning opportunities for physicians, can be a useful resource for Michigan hospitals trying to develop local continuing medical education (CME) programs for their medical staffs.

The need for local, accredited CME programs is particularly acute as a result of the new Michigan law requiring all physicians to document 50 hours of CME participation as a condition of renewal of licensure for 1977.

Media Library, developed by the University of Michigan Medical School's Department of Postgraduate Medicine and Health Professions Education (PGM-HPE), includes a series of slide-sound study programs suitable for individual study or for use in medical staff educational meetings. The program is the result of six years of developmental effort by a multi-professional project team.

Individual programs are 15 to 20 minutes in length and cover topics selected on the basis of their practical value to physicians in primary care specialties. The accompanying syllabus which includes a post-test and reading list allows the physician-learner to explore the topic in greater depth.

Currently, programs are available on over 60 different topics and additional programs are being produced each year.

Equipment necessary to use Media Library has been kept simple and relatively inexpensive, since a major goal of this developmental effort is to produce a CME resource of practical value to physicians who practice in smaller hospitals.

The involvement of practicing physicians, including members of the Education Commission of the Michigan Academy of Family Physicians, contributes to the practical value and quality of Media Library programs and has allowed Media Library to qualify as a source of prescribed credit for members of the American Academy of Family Physicians (AAFP).

Media Library has also been accepted for credit toward the AMA's Physician Recognition Award and by the American Osteopathic Association, the College of Family Physicians of Canada, and the American College of Emergency Physicians.

When used under appropriate conditions, Media Library programs can serve as one source of the Category I credit hours which will be required for relicensure in Michigan.

The Needs for Hospital-Based CME

Larger hospitals, particularly those with house officer training programs, have ongoing, readily available CME opportunities including teaching conferences, special lectures and seminars, and adequate medical libraries. These resources, plus their directors of medical education, support staff and existing educational budgets, make it relatively easy for them to gain accreditation from the MSMS Commission on Continuing Medical Education, and thereby to offer Category I CME credits for their hospitals' medical staff.

The major physician learning resource available in smaller hospitals is the medical library where, typically, a limited number of basic medical texts and some current copies of journals are available. Aside from books and journals, the most widely accepted form of CME in these hospitals is Audio Digest.

The absence of student or house officer training stimuli and the infrequency of local hospital educational meetings often leave physicians practicing in smaller hospitals in isolation from readily available learning opportunities. The new Michigan CME requirements for relicensure law further aggravates the educational inequity between larger and smaller hospitals. Physicians in smaller hospitals must leave their local community and travel to accredited CME courses or scientific meetings as the primary source of their required credit hours.

There has been a growing trend in CME to focus on the local practice setting (the hospital) as the logical learning center for physicians and to link hospital-based CME efforts to specific learning needs identified by the measurement of physician performance against criteria adopted by local physician groups. Such an approach to CME is supported by the standards of the JCAH and by the CME accreditation standards of the MSMS Commission on Continuing Medical Education.

Thus, the physician in Michigan hospitals has multiple motivations to participate in strengthening the CME efforts of his local hospital. The availability and regular use of CME resources such as Media Library can both aid the practitioner in meeting his or her CME credit requirements and the hospital in maintaining its JCAH accreditation.

Media Library Background

Since its organization in 1927, the U of M Department of PGM/HPE has offered a large and varied CME program, including intramural courses and extramural faculty visitors. Media Library is an initial step by the Department to strengthen the CME resources available for use in local hospitals. The Media Library slide-tape programs share high quality CME in a way which eliminates the need for learner or teacher to travel. Media Library is practical, efficient, and yet highly flexible to allow access to the educational material whenever physicians have time available and an interest in viewing the materials.

The origins of Media Library date back to the late 1960's when discussions at the U of M concerning strengthening CME in local hospitals led to a pilot program of experimentation with independent study material. Equipment and programs were field-tested in five hospitals as well as at courses held at the Towsley Center. These tests showed:

1. Physician acceptance of this format was high.
2. Sophisticated equipment was not necessary.
3. Synchronized rather than unsynchronized programs were preferred.
4. Short to medium length programs were preferred.
5. An independent study center in a local hospital should be in an area of reasonably high physician traffic, but at the same time, must have a fair degree of privacy.

Following the encouraging results of the field trials, which had identified a need for well-produced CME materials, a commitment was made to a major effort in the production of quality programs. In 1971, a production unit was established to develop, with faculty authors, programs for use in Media Library. The production format selected was synchronized slide-tape because of its flexibility and relatively low cost. The 15 to 20 minute length of programs and their single concept design are based on learning research and the field trial experience in hospitals.

Video-cassettes or other more sophisticated audio-visual display methods were not selected for Media Library because of the high initial costs of production and equipment, the lack of display equipment standardization, the difficulties in updating programs, and the lack of familiarity with these media formats by physicians and support staff in most local hospitals.

Family physicians and specialists, as well as physicians at the pilot hospitals, were polled for topic suggestions within the guideline of usefulness to practitioners in primary care specialties. The most-mentioned topics were then selected for first-year production. During 1971-72, additional field trials were conducted in six hospitals with fewer than 150 beds to demonstrate that independent study materials could be used in smaller hospitals by physicians.

Based on the experience gained over this three-year period, the Department of PGM/HPE announced the availability of Media Library CME subscriptions in mid-1972. A non-profit financing plan was established, permitting the subscribing institution to select those programs most useful to their staff and to retain them as a readily available library resource. Departmental staff consultation is available to help subscribers plan for the most effective use of Media Library. A newsletter keeps subscribers up-to-date on new topics in production and provides suggestions for innovative uses of Media Library.

Each program produced has a syllabus developed by the faculty author and the production staff. Each syllabus consists of a statement of the educational objectives, a reading reference list, a summary of the program, and a post-test with answers.

Every two years the faculty authors are asked to validate their programs. Any changes necessary are made to update the programs. The ease of this updating process in changing slides or tapes was one consideration in the choice of the slide-tape format for Media Library. Subscribers are notified of the changes and can purchase updated programs.

To make Media Library as useful as possible, each subscriber hospital is surveyed annually about its use of the programs, and asked for suggestions for future topics.

A Media Library Advisory Committee has recently been appointed and serves as a consulting body to the project. The advisory committee includes physician representatives from the Education Commission of the Michigan Academy of Family Physicians and from several subscriber hospitals.

Current Status of Media Library

The most significant difference between Media Library and other available audio-visual learning materials is the intent to make Media Library an interactive process which responds to the identified learning needs of subscribers and proves effective in the local hospital setting.

At the present time, Media Library has over 100 subscribers, including 59 local hospitals, 31 of which are smaller than 200 beds. Larger teaching hospitals and medical schools make up the bulk of the remaining subscribers. In several larger hospitals, Media Library is being used as a learning resource in a family practice residency program.

The low priority currently given to CME in most local hospitals and the resultant lack of budgetary, space and support provision has limited subscription among smaller hospitals — a major target group for Media Library. In contrast, the larger hospitals, particularly those with house officer training programs, have existing budgets available to directors of medical education which allow the acquisition of additional educational resources. Hopefully, the availability of CME credit through Media Library and the impact of JCAH standards will be an incentive for medical staffs, administrators and boards of smaller hospitals to provide funds to acquire learning resources such as Media Library for use in their hospitals.

Individual Use of Media Library

In order for physicians to use Media Library in individual study, our experience suggests that the following conditions must be present:

1. The programs must be ready in trays and easily accessible to the physician.
2. A regular place must be available for viewing and equipment must be ready for immediate use.
3. The viewing location must be relatively quiet and private. (Or earphones must be provided to allow uninterrupted study.)

The hospital library is the most frequently mentioned site for Media Library, and the librarian is usually the staff person who coordinates its use in CME. This role is critically important in assuring use of Media Library, since subscribers report that physicians use the programs only when they are readily available and the equipment is convenient to use.

Many hospitals have extended the availability of Media Library for individual study beyond regular workday hours.

The use of Media Library programs for individual study is, generally, creditable in Category 5A toward the AMA Physician Recognition Award, or for Category 5 credit toward meeting the requirements of the Michigan Medical Practice Board.

Group Use of Media Library

Subscribing hospitals have found that Media Library is easily adaptable for use in CME staff meetings and conferences. A program may serve as a stimulus to staff discussion in lieu of a speaker, or as a supplement to a speaker's presentation. Local physicians speaking at these conferences sometimes use the programs to update their own knowledge prior to their presentation or as a source of visual aids during their presentation.

Group use of Media Library programs can aid physicians in gaining Category I credit toward the AMA Physician Recognition Award if such use is: (1) Part of a planned program of CME, and (2) Supplemented by a local instructor in terms of the educational objectives of the group.

The local CME program at Port Huron Mercy Hospital is one example of planned educational staff meetings using Media Library programs as a learning resource. William Dinnen, MD, an internist responsible for organizing the meetings, reports that attendance at the weekly sessions has climbed from around eight, to 20 physicians. A Media Library program is used as the "guest speaker" for the meeting supplemented by a local physician as discussion leader. Doctor Dinnen notes that their hospital's program was complimented by the JCAH during its most recent visit and that it will also enable them to apply to the MSMS Commission on Continuing Medical Education for approval to grant Category I credits.

Doctor Richards and Doctor Hiss are directors, respectively, of the Offices of Intramural and Extramural Education, U-M Department of Postgraduate Medicine and Health Professions Education. Doctor Hiss also is a U-M professor of internal medicine. Doctor Work is associate professor of Ob-Gyn and faculty coordinator, Independent Study Production Unit in the U-M postgraduate medicine department. Doctor Dean is a family physician and member, Education Commission, Michigan Academy of Family Physicians.

References

1. Rogers, James A., *A Survey of Continuing Physician Education in New Jersey Hospitals,* New Jersey Regional Medical Program (1969).
2. Mann, Floyd; Kotre, John; Reilly, Anthony; and Vanselow, Neal: "The Michigan Physician and His Continuing Education," *Michigan Medicine* (November, 1970) :989.

category 1 programs

***Michigan Medicine** each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

Date: April 6-7, 1976 — Obstetrics & Gynecology Conference
Location: U-M, Towsley Center, Ann Arbor, MI 48109
Sponsor: Department of PGM/HPE
For: Obstetricians, Gynecologists
Cost: $100
Physicians-in-Training — Undetermined
Contact: U-M Office of Intramural Education*
Approved for: 11 hours of Category I Credit

* * *

Date: April 7-June 16, 1976 — Clinical Radioisotope, Theory and Application (2 hrs weekly)
Location: Scott Hall, WSU, 540 E. Canfield, Detroit, 48201
Sponsor: WSU Department of Pathology
For: Hospital Pathologists
Cost: $154.00
Contact: WSU Continuing Medical Education **
Approved for: Hour for hour Category Credit

* * *

Date: April 7-8, 1976 — Quality Assurance Tutorial
Location: Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor 48105
Sponsor: CPHA
For: PAS member hospital teams
Cost: Hospital team of five members, $155
Contact: CPHA, 1968 Green Road, Ann Arbor, 48105
Approved For: 13 Hours of Category I Credit

* * *

Date: April 9, 1976 — Cardiac Rehabilitation Symposium
Location: Borgess Hospital Auditorium
Sponsor: Borgess Hospital
For: Internists and chest physicians
Cost: None
Contact: Cardiac Rehabilitation Center, Borgess Hospital, 1521 Gull Road, Kalamazoo, MI 49001, 616 383-8340
Approved for: 7 hours of Category I Credit, for members, American Academy of Family Physicians, only; all others receive Category II credit

* * *

Date: April 9-10, 1976 — Ninth Annual Cancer Symposium: Cancer of the Prostate
Location: WSU Scott Hall
Sponsor: Wayne State University Department of Oncology
For: Urologists and Surgeons
Cost: $25.00
Contact: WSU Continuing Medical Education**
Approved for: 12 Hours of Category I Credit

* * *

Date: April 20-22, 1976 — EKG Diagnosis
Location: U-M Towsley Center
Sponsor: Department of PGM/HPE
For: Gen. Practitioners, Internists
Cost: $150
Contact: U-M Office of Intramural Education*
Approved for: 23 hours of Category I Credit

* * *

Date: April 29-May 1 — Critical Care Symposium: Current Concepts in the Care of the Critically Ill
Location: Wayne County Medical Society, 1010 Antietam, Detroit
Sponsor: Wayne State University, Department of Surgery, Michigan Committee on Trauma of the American College of Surgeons, Michigan Chapter American College of Chest Physicians
For: Emergency — critical care and primary care physicians
Cost: $95.00 for practicing physicians
$45.00 for nurses, technicians and residents
Contact: Lynn Ernest, Department of Surgery, WSU, 540 E. Canfield, Detroit 48201
Approved for: 20 Hours of Category I Credit

* * *

Date: May 6-7, 1976 — 19th Annual Clinic Days — Symposium on Pediatric Drug Therapy
Location: Children's Hospital, Detroit
Sponsor: Wayne State University Department of Pediatrics
For: Pediatricians and family physicians
Cost: $100.00
Contact: WSU Continuing Medical Education
Approved for: 14 Hours of Category I Credit

* * *

Date: May 6-7, 1976 — Opthalmology Conference — Strabismus
Location: Towsley Center for Continuing Education, Ann Arbor
Sponsor: U of M Department of PGM/HPE
For: Ophthalmologists
Contact: Towsley Center for Continuing Education, Ann Arbor, MI 48104
Approved for: 15 Hours of Category I Credit

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* Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**Continuing Medical Education, 1206 Scott Hall, 540 E. Canfield, Wayne State University, Detroit 48201.

Date: May 7-8, 1976 — Board Review in Nuclear Medicine
Location: Towsley Center, University of Michigan, Ann Arbor
Sponsor: U-M Office of PGM/HPE
Cost: $110.00
Contact: U-M Office of Intramural Education*
Approved for: 16½ hours of Category I Credit

* * *

Date: May 7-8, 1976 — A Symposium for the Practicing Physician: Applied New Concepts on Rheumatology
Location: Hyatt-Regency, Dearborn Michigan
Sponsor: Michigan Chapter, Arthritis Foundation
For: General Medicine, Rheumatologist — Arthritis
Cost: Physicians, $25 including luncheon
Residents & Fellows, $10.00
Students, no cost
Contact: Michigan Chapter Arthritis Foundation, Village Plaza, Suite 605, 23400 Michigan Avenue, Dearborn 48124
Approved for: 10 Hours of Category I Credit

* * *

Date: May 12-13 — Quality Assurance Tutorial
Location: Ann Arbor (See April 7-8)
Sponsor: Commission on Professional and Hospital Activities
For: PAS member hospital teams
Cost: Hospital team of five, $155
Contact: CPHA, 1968 Green Road, Ann Arbor, MI 48105
Approved for: 13 Hours of Category I Credit

* * *

Date: May 13-14, 1976 — Advances in Cardiac Pacing
Location: U-M, Towsley Center, Ann Arbor 48109
Sponsor: Department of PGM/HPE
Co-Sponsor: American Heart Association, Council of Clinical Cardiology
For: Cardiologists, Thoracic Surgeons
Cost: Practicing Physicians — $120/65
Physicians-in-Training — $60/35
Contact: U-M Office of Intramural Education*
Approved for: 14¾ Hours of Category I Credit

* * *

Date: May 17-21, 1976 — Advances in Internal Medicine
Location: Towsley Center for Continuing Education
Sponsor: U of M Medical School PGM/HPE
For: Internal Medicine
Cost: $220 or $55/day for practicing physicians
$110 or $30/day for physicians in training,
plus $12.00 dinner fee
Contact: U-M Office of Intramural Education
Approved for: 31 Hours of Category I Credit

* * *

Date: May 22, 1976 — Pediatric Forensic Pathology Conference
Location: E. W. Sparrow Hospital, 1215 E. Michigan, Lansing
Sponsor: E. W. Sparrow Hospital
For: Pediatricians and pathologists
Cost: None
Contact: Gladys M. Tomas, PhD, Department of Pathology, E. W. Sparrow Hospital, Box 480, Lansing 48902
Approved for: 4 Hours of Category I Credit

* * *

Date: June 7-11, 1976 — Principles and Practice of Industrial Toxicology
Location: Hyatt Regency, Dearborn
Sponsor: Wayne State University Department of Occupational and Environmental Health
For: Industrial physicians, public health officials, hygienists
Cost: $350.00
Contact: WSU Continuing Education**
Approved for: 14 Hours of Category I Credit

* * *

Date: June 30-Sept. 8 — Instrumentation in Clinical Biochemistry (2 hours weekly)
Location: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
Sponsor: WSU Department of Pathology
For: Hospital pathologists
Cost: $154.00
Contact: WSU Continuing Medical Education**
Approved for: Hour for hour Category I Credit

Heart Days '76 April 29-30 at Hyatt-Regency

Michigan physicians have a special invitation to the Heart Days '76 program of the Michigan Heart Association, scheduled April 29-30 at the Hyatt Regency Hotel, Dearborn.

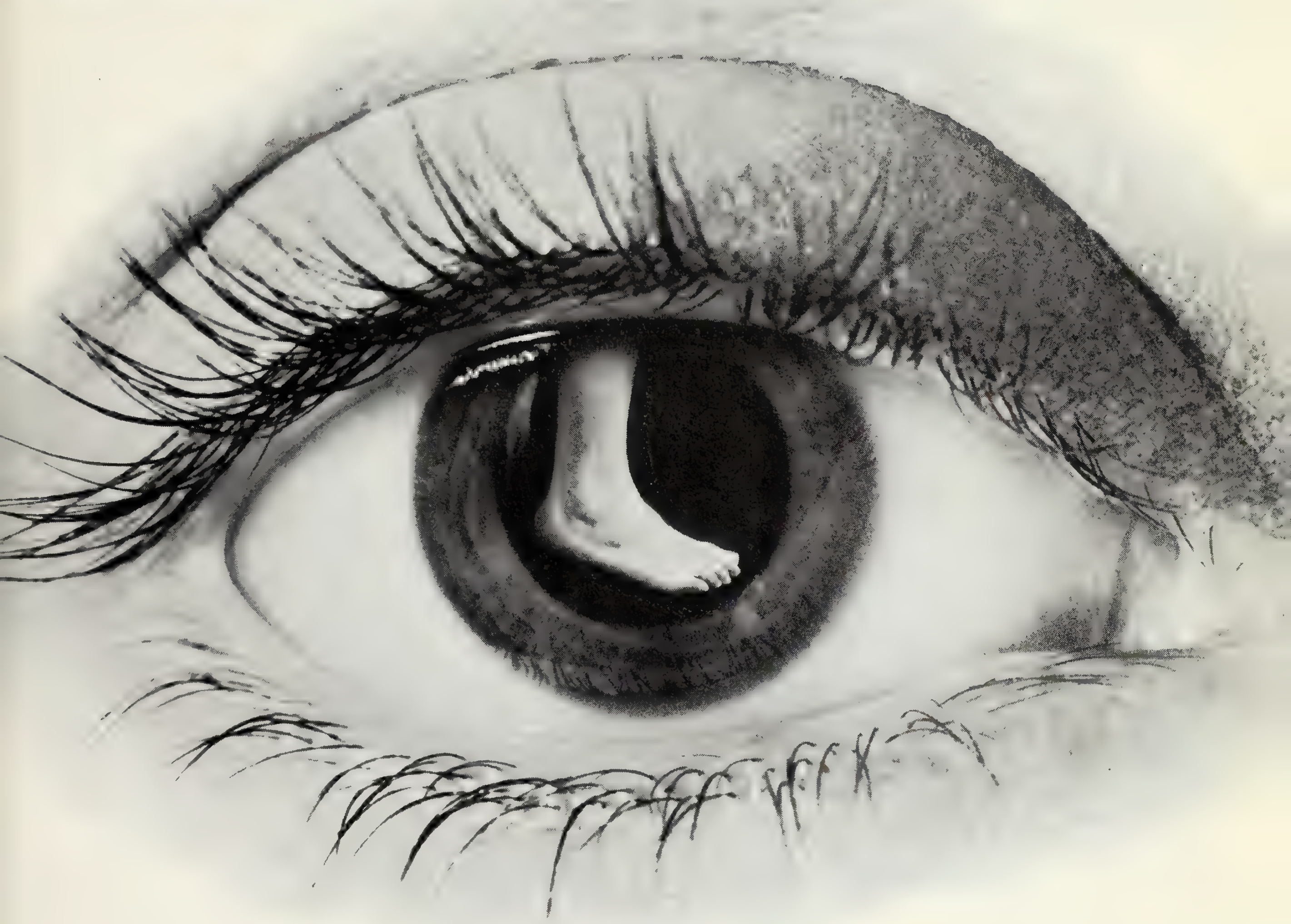
Registration is scheduled from 8 to 9 a.m. Thursday, April 29, for the first day's program, which is of special interest to doctors. It begins at 9 a.m. with two workshops, one on acute coronary care and the other on "Prolapse, IHSS, Functional Murmur."

The keynote address at noon will be given by O. Howard Reichman, MD, associate professor, Division of Neurological Surgery, Loyola University. The traditional Wilson-Myers Lecture will be delivered at 1:30 p.m. by Nanette K. Wenger, MD, professor of medicine, Emory University, who will discuss "Cardiac Rehabilitation." Doctor Wenger will conduct a clinical session following her talk.

Four concurrent workshops are scheduled in the afternoon. The subjects are post-coronary rehabilitation exercise, the nursing perspective of inpatient rehabilitation and teaching, the choice between disability or a job, and a community hospital program for rehabilitation.

Registration for physicians is $25. Further information may be obtained from the Michigan Heart Association, PO Box LV 160, Southfield, 48076. Category I credit has been applied for.

consider the effect on coexisting glaucoma when you prescribe a vasodilator*



a vasodilator that has not been reported to raise intraocular pressure

VASODILAN®

(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

MEETINGS

(See also listing of Category I programs on page 181)

April 15 — General Meeting and election of officers, Michigan Ophthalmological Society, 5:30 p.m. reception at Wayne County Medical Society Headquarters, contact: Phillip Hessburg, MD, sec., MOS, 15401 E. Jefferson, Grosse Pte. Park 48230

April 21 — Annual Residents Day Meeting, sponsored by the American Urological Association, Inc., at the Wayne County Medical Society Building on 1010 Antietam Road, Detroit, contact: Joseph R. Oldford, MD, 23700 Orchard Lake, Farmington Hills 48024

April 21 — Colloquium on Cancer, "Estrogen Receptors and Hormone Dependency," Life Sciences Building auditorium, Michigan State University College of Human Medicine, contact: James Trosko, MD, MSU Department of Human Development, Life Sciences Building, MSU, East Lansing, 48824

April 26-30 — AMA Seminar on Negotiations, at Hillsdale College (Fee: $750, including room and board), contact: Department of Negotiations, AMA, 535 N. Dearborn, Chicago 60610

April 28 — PSRO Workshop on medical care evaluation studies, sponsored by Michigan PSRO Support Center, at Weber's Inn, Ann Arbor, limited attendance, contact: Herbert Mehler, Project coordinator, PSRO Support Center, PO Box 950, 120 W. Saginaw St., East Lansing, 48823.

April 29-30 — Annual Heart Days, sponsored by Michigan Heart Association, at Hyatt Regency Hotel, Dearborn, Categ. I credit applied for, contact: Dennis Hampton, PO Box LV160, Southfield 48076

April 29-May 1 — Critical Care Symposium at Wayne County Medical Society Headquarters, 1010 Antietam, Detroit, contact: Don Burkholder, WSU University Relations — School of Medicine, 540 E. Canfield, Detroit 48201.

April 30-May 2 — MSMS House of Delegates, Troy Hilton, contact: Richard Campau, MSMS Headquarters

May 1 — Sixth Annual Workshop, "Acquired Neurogenic Disorders of Communication," sponsored by Michigan Speech Pathologists in Clinical Practice, at Michigan Inn, Southfield, contact: JoAnn Robbins, 261 Mack Boulevard, Detroit 48201

May 4 — Michigan Cancer Coordinating Committee Meeting, MSMS Headquarters, contact: Helen Schulte, MSMS Headquarters

May 5 — Medical Practice Board, at 1116 S. Washington Ave., Lansing, contact: Bert C. Brennan, 1033 S. Washington Ave., Lansing 48926

May 6-7 — 19th Annual Clinic Days, "Pediatric Drug Therapy," sponsored by Children's Hospital of Detroit and WSU School of Medicine, at Children's Hospital, Detroit Medical Center, contact: Alan K. Done, MD, chairman, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit 48201

May 12-14 — Joint Michigan/Ontario Chapter Meeting, American College of Emergency Physicians, at Four Seasons Hotel, Toronto, Ontario, Canada, contact: ACEP, 241 East Saginaw, East Lansing 48823

May 14-16 — Central States Meeting, Michigan Dermatological Society, at Hyatt Regency, Dearborn, contact: James D. Stroud, MD, 15901 W. Nine Mile Rd., Southfield 48075

May 19 — Annual Meeting, Michigan Allergy Society, contact: B. David Wilson, MD, Sec., MAS, 4615 W. Main St., Kalamazoo 49007

May 19 — 108th Annual WSU Medical Alumni Reunion Day, Michigan Inn, Southfield, contact: Don Burkholder, PhD, WSU University Relations-School of Medicine, 540 E. Canfield, Detroit 48201

May 27-28 — Committee Meeting on Maternal and Perinatal Health at Gull Lake MSU Conference Center, contact: Helen Schulte, MSMS Headquarters

June 1-3 — Annual MCAAP Meeting, at Bay Valley Inn, Bay City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48024.

June 2-4 — Annual Meeting, Michigan Public Health Association, Grand Hotel, Mackinac Island, contact: LaRue Miller, executive director, MPHA, 403 Seymour, Lansing

June 15-18 — Symposium on Childhood Deafness, sponsored by Central Michigan University, at CME, contact: Mr. Lynn Kindel, Off Campus Education, CMU, Mt. Pleasant 48859

June 17-19 — Annual Keyport Trauma Symposium, sponsored by the Michigan Committee of the American College of Surgeons, at Otsego Ski Club, Gaylord, Michigan, contact: B. E. Henig, MD, 308 Michigan Avenue, Grayling 49738

June 21-25 — 12th Annual Northern Michigan Summer Conference, sponsored by U-M Department of Post Graduate Medicine and Health Professions Education, at Shanty Creek Lodge, Bellaire*

June 26-July 1 — AMA Annual Convention, Dallas

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*Contact: Robert K. Richards, Director, Office of Intramural Education, Room 6-1109, Towsley Center for Continuing Medical Education, University of Michigan Medical Center, Ann Arbor 48109

**Contact: Dr. Anna B. Brown, Director of Continuing Education, 3550 School of Public Health I, The University of Michigan, 109 S. Observatory Street, Ann Arbor, MI 48109

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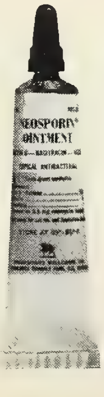
Bare-knuckles heavyweight champion
1882-1892

NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).



Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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New orange-flavored Kay Ciel®

(potassium chloride 10%)

Elixir

The only orange-flavored
KCl Elixir

Advantages over
tablets and diet:

1. Low dose
2. Preferred liquid form
3. Low calories
4. Physician control

KAY CIEL® Elixir
(potassium chloride 10%)

Description: Each 15 ml. (tablespoonful) elixir contains:
Potassium Chloride . . . . 1.5 g.
(supplying 20 meq.)
Alcohol 4% in a palatable base. Contains no sugar.

Indications: Treatment and prevention of potassium deficiency occurring especially during thiazide diuretic or corticosteroid therapy, digitalis intoxication, low dietary intake of potassium, or as a result of excessive vomiting and diarrhea and for correction of associated hypochloremic alkalosis.

Contraindications: Impaired renal function, untreated Addison's Disease, dehydration, heat cramps and hyperkalemia.

Warnings: Do not use excessively.

Precautions: Administer with caution and adjust to the requirements of the individual patient. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis. ***Patients should be cautioned to adhere to dilution instructions.***

Adverse Reactions: Potassium intoxication indicated by listlessness, mental confusion, paresthesia of the extremities, weakness of the legs, flaccid paralysis, fall in blood pressure, cardiac depression, arrhythmias, arrest and heartblock. Vomiting, nausea, abdominal discomfort and diarrhea may occur.

Dosage and Administration:
One 15 ml. tablespoonful (20 meq. of potassium chloride) ***diluted*** in 4 ounces of water or fruit juice twice daily (preferably after a meal), or as directed by physician.

Overdosage: In case of excessive use resulting in hyperkalemia or potassium intoxication, discontinue use of potassium chloride administration or take other steps to lower serum levels if indicated.

How Supplied: Bottles of:

473 ml. . . . . NDC 0041-0145-16
3785 ml. . . . . NDC 0041-0145-28

How to make orange juice really effective K⁺ therapy

and supply the chloride most patients need with potassium supplementation

Potassium-"rich" orange juice actually only contains about 1 meq. per ounce. To reach effective maintenance levels, your patients would have to drink about 40 ounces of orange juice a day.

But now, new orange-flavored Kay Ciel mixes tastily with your patient's morning juice, one tablespoon supplying 20 meq. each of elemental potassium and chloride.... About four times the K+ in orange juice alone. Repeat in the evening for a full therapeutic regimen. Or, if you want your patient to avoid the extra calories, new orange-flavored Kay Ciel tastes great by itself in four ounces of water.

You can be sure your patients will get the KCl they need...in a way they'll like.

New Orange
Kay Ciel
Elixir

New Orange-Flavored
Kay Ciel® Elixir
(potassium chloride 10%)

One tablespoon (15 ml.) supplies 20 meq. each of elemental potassium and chloride

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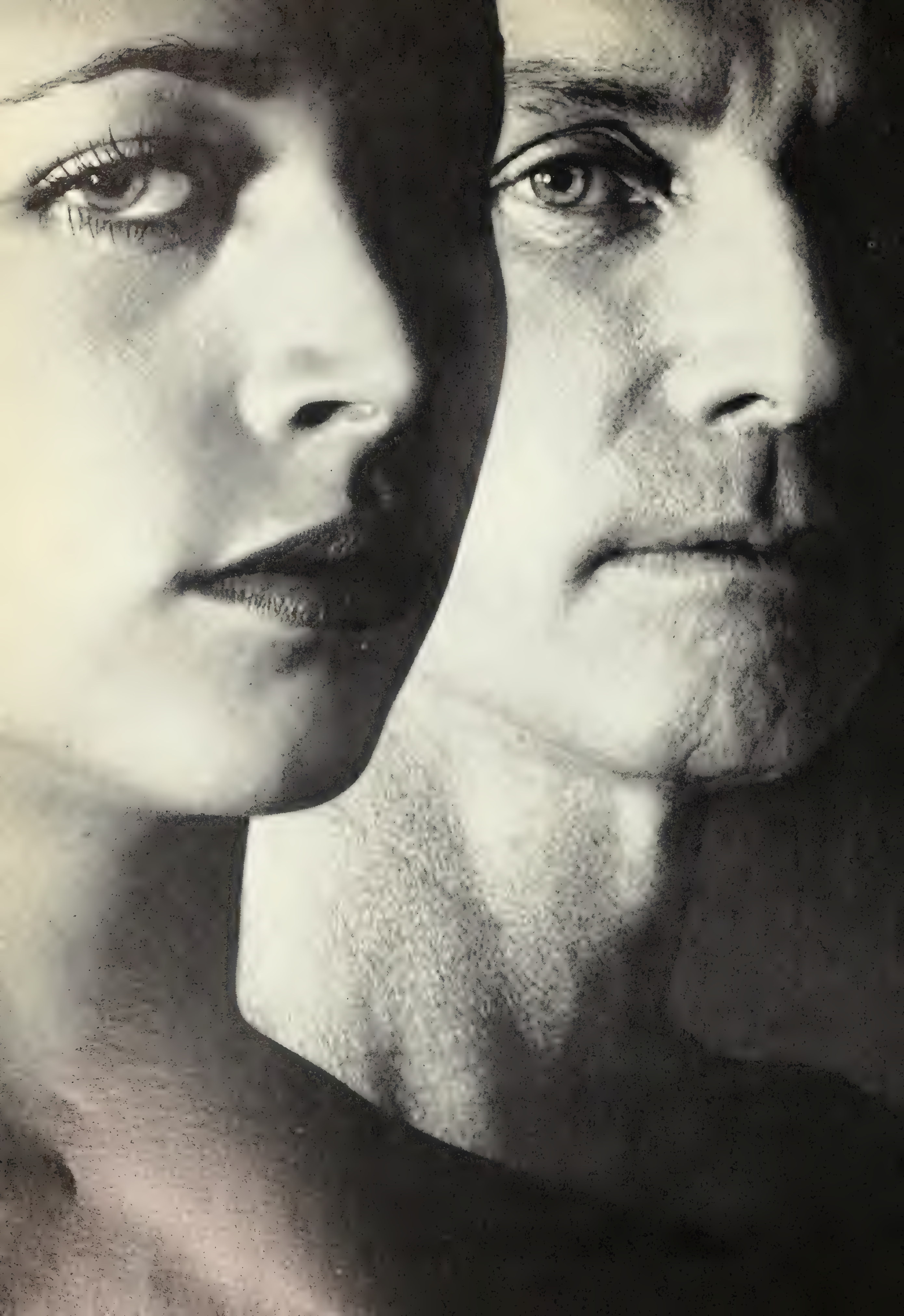


Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct nontherapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

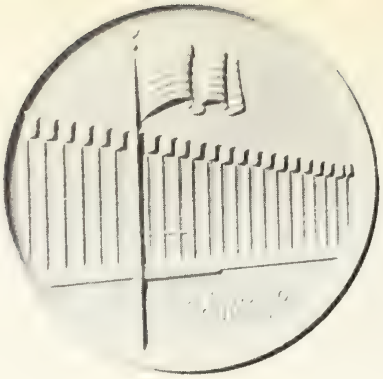
12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005



Your delegates will follow this schedule April 30-May 2 in Troy

Continuing medical education requirements for relicensure, attorneys' contingency fees and pre-surgical screening programs are shaping up as major issues to confront delegates to the 1976 MSMS Annual Session of the MSMS House of Delegates April 30-May 2 at the Troy Hilton, Troy.

Approximately 150 physicians from around Michigan will travel to Troy on those days as representatives of component societies, specialty societies, MSMS specialty sections, and medical schools to decide the direction of MSMS action during the coming year.

They will meet for the first time in weekend sessions, to take less time from their regular practices.

In addition to considering the many resolutions submitted in advance from their component societies, the delegates will select new officers, including the MSMS president-elect, and AMA delegates.

Highlights of the meeting will include a seminar with the sponsor of the Keogh retirement plan, former Congressman Eugene J. Keogh of New York, and another seminar on professional liability. MDPAC will stage its annual luncheon and the House Officers Association will conduct a business session.

In addition, awards will be given to physicians who are presidents of national medical associations, non-medical state organizations, and physicians who have practiced for 50 years.

The schedule of events is as follows:

Friday, April 30

10 a.m. — Council meeting
4-8 p.m. — Registration
7:30 p.m. — FIRST MEETING, MSMS House of Delegates

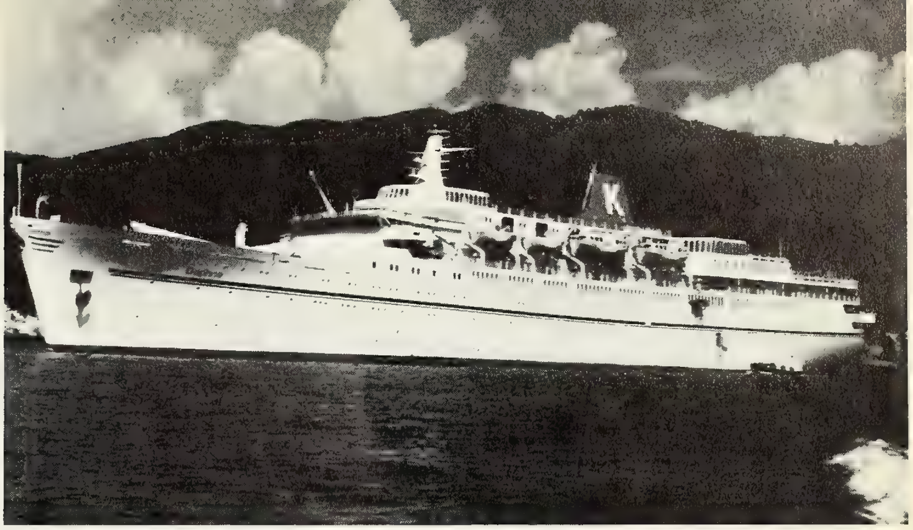
Saturday, May 1

8:30 a.m. to noon — Reference Committee Hearings
Noon — Annual MDPAC Luncheon
2:30 p.m. — SECOND MEETING, MSMS House of Delegates
3:30 to 4:30 p.m. — Seminar on Physician Retirement and Estate Planning
4:30 to 5:30 p.m. — Seminar on Professional Liability
7 p.m. — President's Installation Dinner

Sunday, May 2

9 a.m. — THIRD MEETING, MSMS House of Delegates
10 a.m. — House Officers Association Business Session
2 p.m. — FOURTH MEETING, MSMS House of Delegates
4 p.m. — Council meeting

Complete information may be obtained from Richard Campau at MSMS headquarters.



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Governor Milliken declares May 2-8 "MSMS Auxiliary Week"

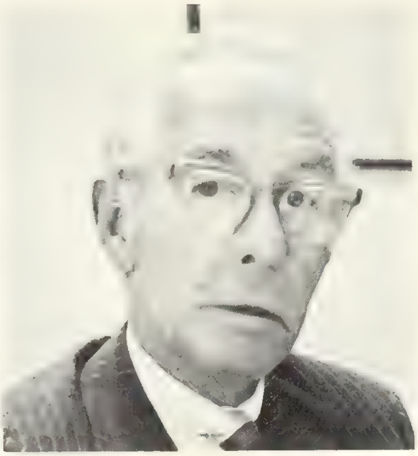
MSMS Auxiliary members will celebrate May 2 through 8 as "MSMS Auxiliary Week," formally declared by Gov. William Milliken. The dates coincide with the 1976 annual meeting of the Auxiliary May 3-5 at the Troy Hilton Inn, Troy.

In honoring the Auxiliary on its 50th year, Gov. Milliken urged all citizens "to make themselves aware that these women serve most effectively in supporting many essential projects that contribute to the health and happiness of the citizens of our state through their active interest and meaningful participation."

"The approximately 3,500 members of the auxiliary . . . engage in varied programs and many worthwhile activities — including education and research, health careers, health education, mental health education, international health, world medical relief, community service and home-centered health care — as well as working with community groups in meeting local health needs," he said. "The auxiliary's contributions to the welfare, happiness and well-being of all are important to all communities in Michigan."

Mrs. S. A. Yannitelli, Battle Creek, is 1975-76 Auxiliary president. Mrs. F. P. Rhoades is 50th anniversary and convention chairman.

Eugene Keogh seminar speaker Annual Session



Mr. Keogh

The sponsor of legislation establishing the Keogh plan, which many Michigan physicians now use to arrange for their own retirement, will speak at the 1976 Annual Session of the MSMS House of Delegates April 30-May 2 at the Troy Hilton Inn, Troy.

The Keogh Plan author is former Congressman Eugene J. Keogh of New York. Mr. Keogh will address a forum on retirement scheduled from 3:30 to 4:30 p.m. Saturday, May 1 in the Oakland Hills and Meadows Rooms of the Hilton. The session is open to any interested MSMS member.

Under the Keogh Plan, which was devised to aid self-employed persons without pension plans established by their business firms, physicians may set aside up to $7,500 per year of tax-free earnings toward their retirement.

Two tax breaks actually result. There is the original deferment on all money set aside. There also is a deferment on the interest accrued by the money set aside. Taxes must be paid when the physician retires and begins to draw on the set-aside money; but by then the doctor probably will be in a lower tax bracket.

Physicians may place Keogh Plan retirement savings in special government bonds, a trusteed investment fund or custodial bank account, insurance company annuities, or life insurance.

The landmark Keogh Act was passed in 1962, with a provision to workers without pensions added in 1974.

Mr. Keogh, a native of Brooklyn, practices law in New York City. He was a member of Congress for 30 years and served on the House Ways and Means Committee. He is a trustee, director and consultant of several firms, including the Physicians Planning Service, and chairman of the Franklin Delano Roosevelt Memorial Commission.

Cong. Ruppe to address MDPAC luncheon

Congressman Philip E. Ruppe, Republican from Michigan's Upper Peninsula, will be among speakers at the annual MDPAC Luncheon at noon May 1 during the MSMS House of Delegates Annual Session. The location will be the Troy Hilton Hotel, Troy.

Another speaker is yet to be named.

The MDPAC Luncheon annually brings together the state's politically-minded physicians and their national lawmakers, who have the opportunity to describe proposed legislation and their own opinions of the background and impact of that legislation.

Traditionally, the speaker answers doctors' questions following the talk.

Congressman Ruppe is an Upper Peninsula native, and has been a representative since 1966. He is involved in environmental legislation, as well as legislation to improve the economic status of rural America. He is former president of the Bosch Brewing Company and makes his home with his wife and five daughters in Houghton.

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LETTERS

Medical Protective describes its view of arbitration plan

The following is a full text of a recent letter to MSMS in which Medical Protective Company, Fort Wayne, Ind., spells out its feelings with regard to its physician-policyholders who participate in arbitration of professional liability disputes. Medical Protective insures about three-fourths of Michigan physicians.

Dear Members of MSMS,

It has come to our attention that there is a great deal of confusion and misunderstanding concerning the attitude of The Medical Protective Company towards MD participation in the new binding arbitration program. Apparently, some answers to inquiries, both oral and written, had led doctors to believe that their coverage could be placed in jeopardy by signing an arbitration agreement or that The Medical Protective Company is recommending to their insureds that they not participate in the program. Nothing could be further from the truth and no such inferences should be drawn from any communications, past or present.

The coverage of policyholders of The Medical Protective Company will in no way be affected by participation in the voluntary binding arbitration programs. The decision rests with the doctor. The company will defend the interests of insured doctors and will provide them with the same quality specialized services regardless of the forum or format of malpractice claims resolution. Because Michigan's medical arbitration program is unique, The Medical Protective Company has and will continue to work with our policyholders and the Michigan Insurance Bureau to effectively and fairly implement these new laws and to evaluate their impact on the malpractice insurance market.

We hope this letter will clarify this situation and will reassure our policyholders of both continued attention to their interests and continued professional protection exclusively under their policy with The Medical Protective Company.

Sincerely,
W. J. Davey,
Vice President

* * *

"... an invaluable asset in our efforts to be of greater value ..."

I am writing to convey my sincerest and most heartfelt appreciation for the February article about the "University Hospital in Midst of Major Change." The article is an outstanding example of sterling reporting. I think it to be a service to the state medical society and to the health care community as a whole. You captured in a most professional way the spirit and tone of what we are trying to do here in order to make ourselves more useful and productive to the State of Michigan. We do have many shortcomings and we are working hard to overcome these. Not the least of our shortcomings is a tarnished image and injured public relations in certain quarters. Your article represents an invaluable asset in our efforts to be of greater value to private physicians and their patients throughout the State."

Jeptha Dalston, PhD
Director
University Hospital, Ann Arbor

A proposal to gather data on neuroleptics

I want to express the strongest possible concern about how important drugs (the major tranquilizers — neuroleptics) are described in the PDR and in articles and/or talks by scientists, physicians, psychotherapists, etc., as antipsychotic and/or antischizophrenic drugs. Since most of the people who benefit from major tranquilizers — neuroleptics are obviously non-schizophrenic and/or non-psychotic, I would like to know how such labeling got started and perpetuated in the name of science.

I have been prescribing, mainly the major tranquilizers — neuroleptics, since 1959. Most of the people I treat are not, have not been and probably never will be psychotic or even overtly schizophrenic.

The PDR and other communications about these chemicals are so influential that these opinions may be considered the final word by patients and physicians. I've had an increase in the number of patients who don't want to take their medications because they read that it's for the "crazies."

Also, I believe that these valuable drugs are not being used sufficiently, in part, because the family physician:

a) is not likely to view the troubled person as psychotic and/or schizophrenic,

b) is likely to maintain superficial contact with people diagnosed as having such mysterious and frightening conditions,

c) is not likely to have had much experience prescribing these potent, life-saving chemicals for any conditions, including psychosis and/or schizophrenia.

d) is likely to be scared to prescribe a drug with such a long list of warnings and possible side effects.

It is imperative that we begin to correct this distorted labeling of the neuroleptics — major tranquilizers. There is a good deal of evidence that the neuroleptics are indicated for many non-schizophrenic, non-psychotic, neurotic and other psychological conditions.

May I propose that we develop acceptable definitions of specific psychological disturbances, including psychosis and schizophrenia and then circulate a questionnaire to gather data about the neuroleptics used to treat these symptoms and conditions.

Lawrence D. Stieglitz, MD
Kalamazoo

"... the comments selected may seem frivolous without reference to ... entire"

Thank you for reprinting a portion of a series of articles which I prepared for the Bulletin of Oakland County Medical Society (February Michigan Medicine). However, the comments selected may seem frivolous without reference to the entire series. Since most hospitals are operating at nearly 100% occupancy, and have lists of patients waiting for beds, it is obvious that eliminating unnecessary admissions will not reduce costs if beds are still occupied almost 100%, but simply occupied by other patients. The total cost to the community will remain the same.

In fact, shortening hospital stays under conditions of almost 100% occupancy will result in increased costs. This is simply a reflection of the fact that the initial few days in the hospital are the most costly. For example, the first two days for surgical and obstetric patients involve additional operating room and anesthetic charges. After that (in the absence of complications), the longer the stay, the less the average cost per day. Similarly medical admissions often have an initial period of intensive study followed by a variable period consisting of observation with less intensive followup laboratory testing. Again, the longer the stay, the less the average cost per day.

Thus, eliminating unnecessary admissions and reducing the duration of hospital stays will not decrease the cost of medical care for a community unless one additional vital action is taken — and it is only to make possible this additional action that efforts in the former two areas are needed — i.e. the number of hospital beds in the community must be substantially reduced. This is the most important single action which can be taken to reduce the costs of health care. To be successful in this regard will require a a drastic reorganization of thinking on the part of physicians and the public. In the recent past the public (lay and physician) has been programmed to think that hospitals are where medicine is best practiced — even routine medical care, e.g. checkups. After all, where does the President go for his checkup, likewise other prominent people? Hospitals serve a necessary purpose, but they are the location of incredibly inefficient delivery of health care. Their utilization must be reduced so that their size can be reduced.

Sincerely yours,
Joel I. Hamburger, M.D.

How about a Q-A series on CME requirements?

I wonder if it might not be worthwhile having a question and answer section on continuing medical education for the members of MSMS. I'm sure that many of the questions would relate to specific rules and regulations and would best be answered by members of the Michigan Medical Practice Board. However, hopefully, there will be some questions regarding the educational aspects, such as content, organizational structure, evaluation mechanisms, to which members of MAME might be able to respond. If you think this idea has any merit at all, we would be glad to identify someone within MAME who could obtain answers to educational questions for you. Best wishes for the new Michigan Medicine.

Robert B. Carbeck, MD, President
Michigan Association
for Medical Education

(Any MSMS member with questions about CME rules and regulations is invited to write to Michigan Medicine. *They will be answered as quickly and completely as possible. – The editors)*

"... the best publication ..."

The February, 1976, issue of *Michigan Medicine* is absolutely the best publication of its kind I have ever seen. It is, in my view, exactly what a medical journal should be today, how it should look, and why it should exist. The benefits to both your members and your advertisers are everywhere evident. I hope you are receiving their appreciation.

Best wishes,
Ann Gray
Managing Editor
Virginia Medical Monthly

professional management

Here are some good suggestions for improving your office efficiency

By R. Timothy Hogan
Ann Arbor

It is worthwhile for the physician to take the time to observe and evaluate office facilities, routine and staff, as well as his/her own routines and habits for the purpose of improving office efficiency. One way of achieving this evaluation is to follow the progress of a patient from the time he/she enters your office, receives medical care and then leaves.

Three of the more important aspects of an efficient practice to be observed during the patient's office visit are: (1) office facilities, (2) staff personnel, and (3) office routines, records and systems.

If you sit in your waiting room or examining room and observe what patients see and hear you may gain a different impression from what you believe you convey to patients. The old saying, "If we could only see ourselves as others see us," might also be applied to physicians and their practice of medicine. Is one of your staff assigned the responsibility of routinely checking your waiting room for appearances? Current magazines should be available and arranged neatly.

Is your office layout designed to permit a smooth flow of patients from entrance to exit? Your business office and receptionist should be located so patients must stop at the reception desk upon entering and leaving. Can conversations with patients be overheard in the waiting room or examining room next door? Privacy in telephone conversations, or discussion of delinquent accounts should be afforded your secretary and patients.

Your secretary and nurse should use discretion when making appointments by name and disease. "Mr. Jones' gonorrhea check at 2 P.M. on Thursday" should not be shared with all the patients in your waiting room.

The design and proper use of your office facilities contribute greatly to an efficient office practice. Adequate and ample office, and medical equipment and instruments are also a necessary part of your office facilities and should be reviewed for additions or improvements.

Many times a patient's first impression of the physician is the secretary or nurse. They are your representatives and should be instructed in the method you desire to practice medicine and treat patients.

Hiring and interviewing are essential to obtaining better-than-average personnel. You should be specific in a job description and the qualifications you require. An application form should be filled out and reviewed and prior employers contacted. The physician should conduct the final interview and be responsible for hiring and firing. New employees should be hired on a three-month probationary period. You should also have a written office policy regarding salary increases, fringe benefits, hours, sick and vacation time and dress. It is interesting to note that usually employees are a reflection of their employer.

Adequate staffing and para-medical personnel extend the physician's time. They allow the doctor to see more patients without putting in additional time. But caution must be observed as para-medical personnel must be properly supervised and adequate records must be maintained to insure against diminishing returns both medical and financial.

The physician must develop a routine and system in the office to insure proper management of a patient before he/she arrives at the office. This can be accomplished through an appropriate appointment system and scheduling.

Appointments and scheduling are the basis for controlling the flow of patients in the office. The appointment schedule should be realistic and take into account the individuality and the capabilities of the physician involved. Time should be left in the schedule each day to see emergency patients if practice so dictates. The scheduling of various types of appointments throughout the day or week should be reviewed, discussed and understood by the physician's secretary.

There are many types of medical history forms, varying from a preprinted interview form to a plain sheet or card, or a combination of the two. Needless to say, with today's malpractice climate, it is mandatory to keep detailed medical records of the treatment of patients. This should also include a record of telephone calls, referrals, medical tests and sample medications.

A financial history card for each patient or family should be prepared and maintained for billing, insurance and collection purposes. This information should be obtained and recorded at the time of service for patients seen in the office. Patients should be informed of the charge for today and payment requested at the time of service when possible. Additional records are necessary for tax purposes including income and expense summaries and payroll records. In case of a tax audit, the burden of proof is up to the taxpayer. The physician must have adequate records to substantiate income and deductions. Proper forms and records also enable doctor and staff to work more efficiently, permit charting of financial progress and management decisions. While reviewing office facilities, personnel, routines and records it should become obvious that the individual physician is the primary factor in maintaining an efficient practice.

Mr. Hogan is a consultant with Professional Management, Black and Skaggs Associates.

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Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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MATERNAL HEALTH DESK REFERENCE CARD NO. 19

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society)

FETAL-MATERNAL ELECTRONIC MONITORING

The purpose of this reference card is to introduce the practitioner to the concepts of fetal-maternal electronic monitoring during the course of labor. It must be stressed that this information does not provide the reader with a total understanding of monitoring.

Fetal-maternal electronic monitoring is the use of a suitable instrument to measure simultaneously fetal heart rate and maternal uterine contractions. Monitoring may be performed using indirect noninvasive external techniques. The converse of this is internal or direct monitoring. Most presently available equipment has these capabilities. In most cases the information obtained will be confirmation of a healthy fetus. The most accurate route for obtaining this information is by the use of internal monitoring using direct intrauterine pressure measurement of contraction intensity measured on a continuously recorded time base. Simultaneous recording of the fetal heart rate is obtained by direct measurement from the fetal EKG obtained by direct application of an electrode to the fetus. External measurement of these parameters requires the use of an external pressure transducer such as a tocodynamometer which gives relative pressure measurements. A microphone or ultrasound sensing device is used to record fetal cardiac activity. Both the measurement of uterine activity and fetal cardiac activity externally are subject to a great deal of artifact generation and imprecise data.

The priorities for fetal-maternal electronic monitoring use include high-risk conditions such as:

1. Oxytocin or other uterotonic agents for any indication.
2. Labor abnormalities (including abnormal presentations).
3. Conduction anesthesia, (e.g., caudal or lumbar anesthesia).
4. Maternal or fetal condition placing fetus at risk, eg., diabetes, erythroblastosis, prematurity.
5. Classic fetal distress, i.e., meconium stained amniotic fluid or irregular fetal heart rate as detected by auscultation.

The information obtained from electronic monitoring falls into two categories of which the first is *baseline data.* This is further defined as a baseline rate and the characteristics of variability of the baseline. Appropriate values of rate are:

Normal	120-160 b. p. m.
Tachycardia	160-180 b. p. m.
Marked tachycardia	180 b. p. m.
Bradycardia	100-120 b. p. m.
Marked bradycardia	100 b. p. m.

Baseline variability should be present in the normal patient both as long-term variability and as beat-to-beat variability (available only with technique recording fetal cardiac electrical activity).

Periodic changes observed in fetal heart rate require simultaneously recorded uterine activity data. Most equipment presents this data on a paper record running at a paper speed of 3 cm/min. Each major division of the paper represents one minute and the minor divisions represent 10 seconds. Uterine contraction intensity is measured from 0-100mg/Hg. on the vertical scale of the paper **(Figure 1).** It is essential that this information be accurately recorded. These changes are divided into three categories:

1. Early decelerations
2. Late decelerations
3. Variable decelerations

The significance of these decelerations represents additional data in the management of a patient as is any laboratory aid and is not the sole clinical data source for any particular patient.

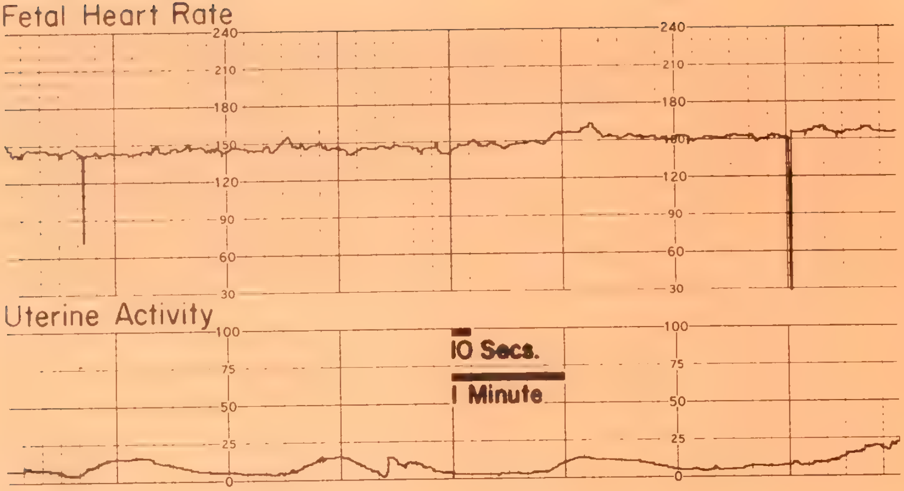

Figure 1

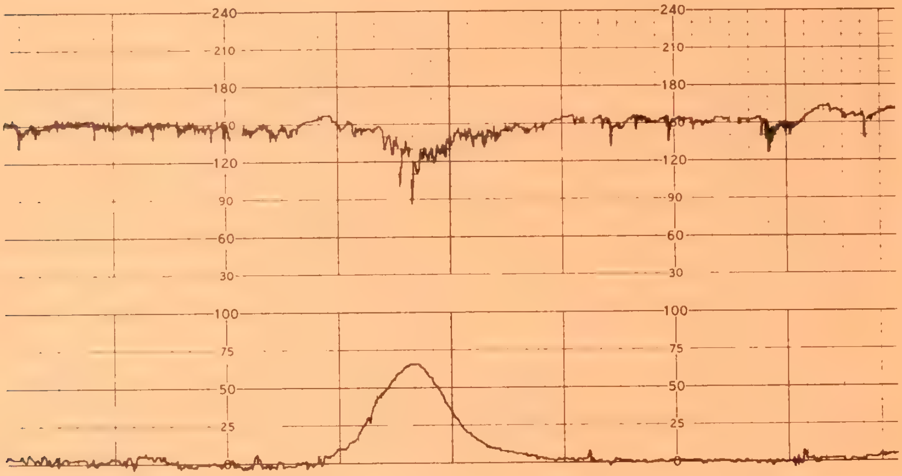

Figure 2

The early deceleration is thought to be vagal nerve stimulation origin and thus usually benign. It is associated with normal pH values on fetal scalp sampling and good Apgar scores at delivery. These decelerations are characterized by a smooth waveform with its onset beginning with the onset of the uterine contraction and reaching its lowest point at the point of maximum intensity of the contraction and returning to its baseline value when the contraction reaches its baseline pressure **(Figure 2).**

Late decelerations may be associated with myocardial hypoxia due to any reason. They have been noted to occur in babies who subsequently demonstrated decreased pH values on scalp blood sampling and lower Apgar scores than babies without this form of deceleration. Late decelerations are characterized as a smooth waveform deceleration with its onset occurring after the onset of the uterine contraction. The late deceleration may frequently have its onset occurring after the peak of the uterine contraction in severe cases. It is characterized by reaching its lowest point after the maximum point of the uterine contraction and frequently even after the uterine contraction has returned to its baseline intensity. In severe cases the fetal heart rate level may not reach its baseline value before the onset of another uterine contraction **(Figure 3).** Late decelerations are seen in association with those conditions in which decreased uterine blood supply is noted, e.g., toxemia, diabetes. Loss of baseline variability and baseline tachycardia are frequently associated with late decelerations. *The presence of late decelerations does not dictate clinical management but does warrant further investigation.*

Variable decelerations are not truly periodic changes but do relate to the contractions. Variable decelerations are variable in their onset, recovery, depth and duration of deceleration. They are found in known situations of cord compromise such as cord prolapse although this should not be considered as the sole etiology **(Figure 4).** They have been noted in a high degree of relationship with the presence of nuchal cords.

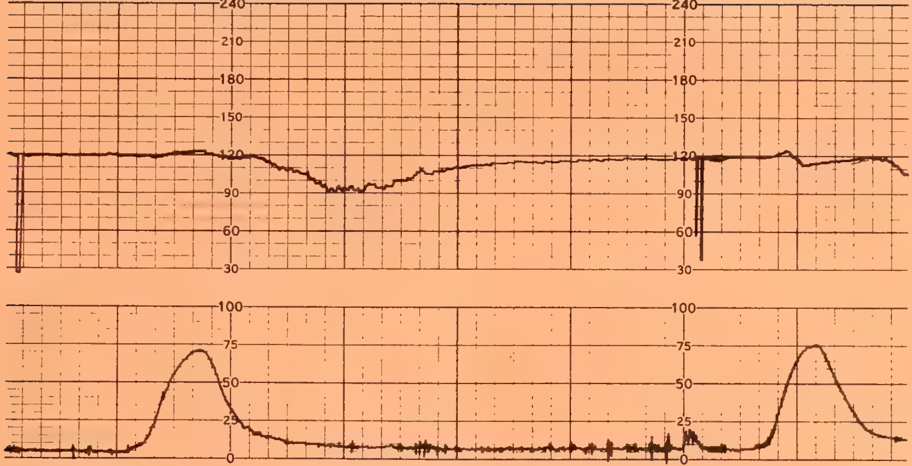

Figure 3

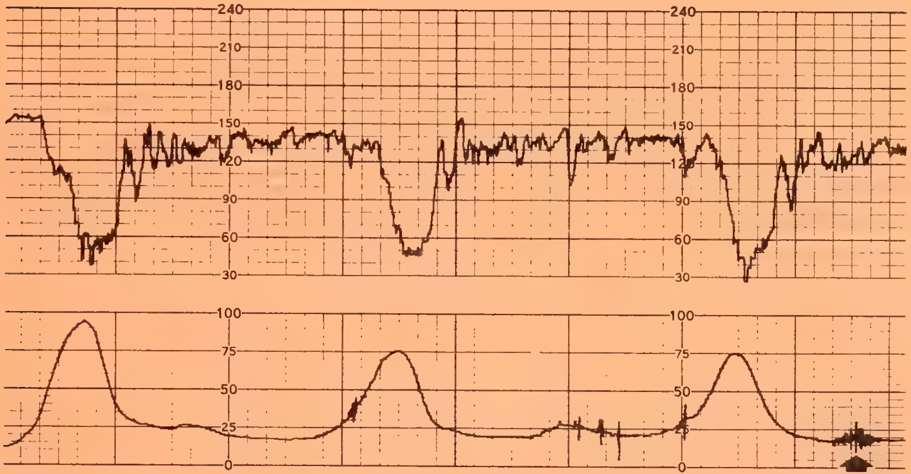

Figure 4

Unfortunately, combinations of these can occur and present a confusing picture. Only training and experience can aid in such cases of possible fetal distress.

Warning signs should be considered as follows:

1. Variable decelerations of a moderate degree (less than serious).
2. Tachycardia greater than 160 p. b. m.
3. Loss of baseline variability.

Serious signs of possible fetal distress include:

1. Variable decelerations lasting greater than 1 minute and reaching a level of 60 b. p. m. or less.
2. Late decelerations with or without baseline tachycardia. If loss of baseline is also noted, a very serious condition exists.
3. Bradycardic episodes lasting through two consecutive contractions.

Appropriate initial management includes:

1. Stop oxytocin if in use, at least temporarily. The reader is urged to refer to the card #3 on oxytocin administration for further discussion.
2. Change patient's position (supine position to be avoided).
3. Administer oxygen at 6-7 liters/minute.
4. Correct hypotension if present.
5. Anticipate delivery. Delivery should be considered in 30-60 minutes if there is no improvement in the pattern which has been noted after instituting the above steps.

6. Fetal scalp blood for pH determination if facilities available.

This information should be considered only as an introduction to fetal-maternal monitoring.

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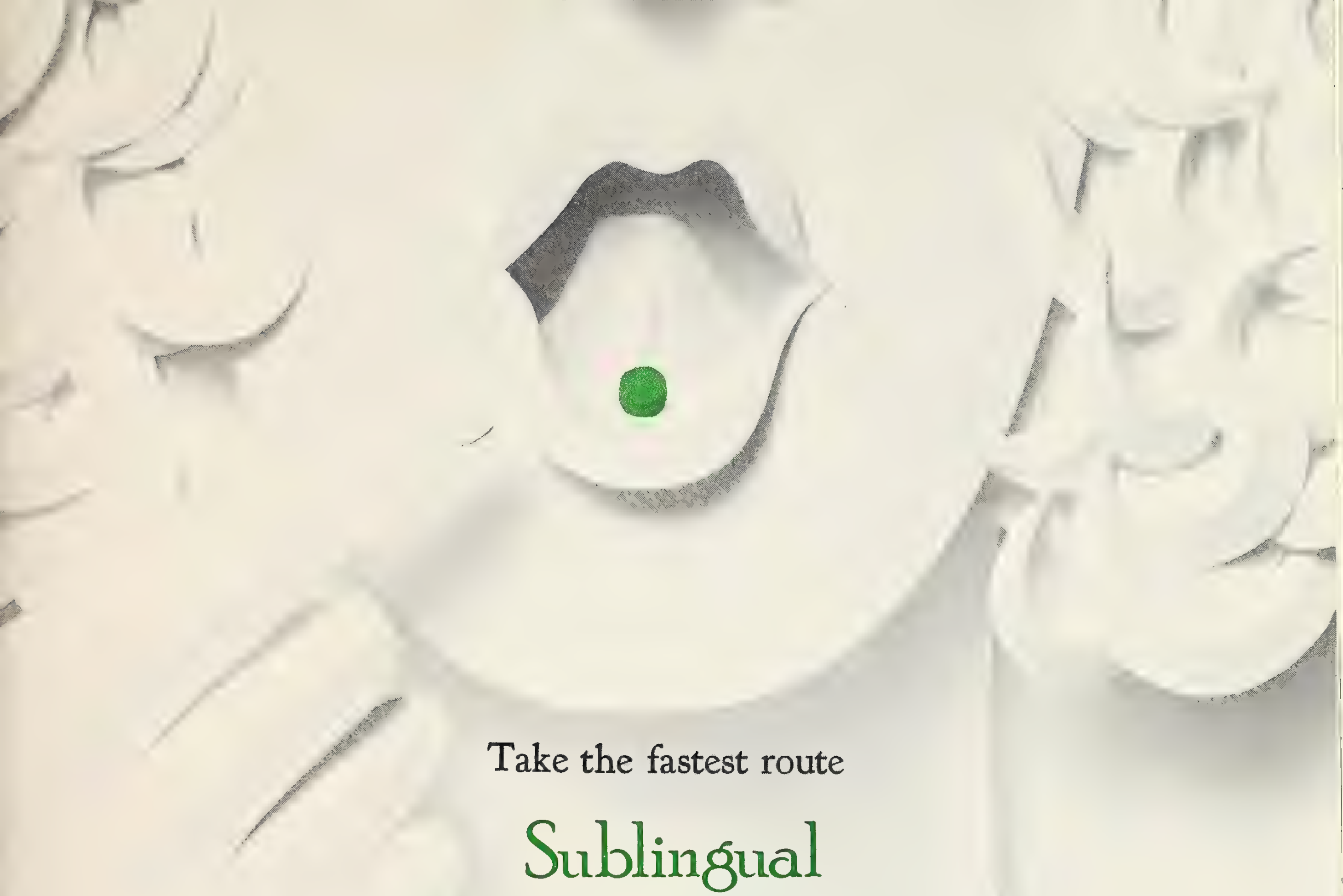
Prepared for the Committee on Maternal and Perinatal Health, Michigan State Medical Society by Bruce A. Work, Jr., M.D., Associate Professor, University of Michigan, Ann Arbor.



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Meeting the many problems of an unexpected infant death

By Jeffrey R. Taylor
Lansing

Medical Examiners throughout the State of Michigan have made use of Act 350 of the Public Acts of 1974 which provides for autopsy at State expense of infants dying under circumstances of sudden death. During 1975, autopsies were done on 130 infants, with 75 percent of the deaths verified as Sudden Infant Death Syndrome. Home counseling programs are being offered by at least twenty-one local health departments. In 1974, three of four "projected" SIDS deaths were reported on resident death certificates. It is recommended that autopsies be done on all infants who die suddenly to determine the specific cause of death

Across the nation, Sudden Infant Death Syndrome (SIDS) is currently the largest single cause of postneonatal infant mortality.[1] An estimated 10,000 die of this condition each year in the United States.[2] Among all infant deaths in Michigan, only congenital anomalies taken as a group claim a higher toll.[3] SIDS or "Crib Death" is usually defined as the sudden and unexpected death of a previously healthy infant (usually between 1 and 6 months of age) which remains unexplained after careful post-mortem studies.[4] Approximately 350 cases of sudden infant death are expected in Michigan each year. These deaths are projected at a rate of 2.5 per 1,000 livebirths.[5]

SIDS almost invariably occurs unobserved during periods when the infant is asleep. Death is not associated with fewer cases occurring during the summer. All studies show a male preponderance, although the incidence of death in males does not ex-

summer. All studies show a male preponderance, although the incidence of death in males does not ex-

ceed that found for infant mortality in general. There is an increased risk of SIDS among low birth-weight babies.[6,7]

Many considerations have led research pathologists to view SIDS as representing a final common pathway in which similar patterns of death are shared by most cases. Death is mediated by a respiratory mechanism and several authors believe the final common pathway is laryngospasm.[8,9,10] A number of new research directions in neurophysiology, cardiopulmonary physiology, blood vessel integrity, infection and immunology have been identified for investigating the disease.[11]

A new statewide program was inaugurated to meet the many problems caused by an unexpected infant death. This program, initiated by legislation, has been conducted by the Michigan Department of Public Health. Program development and results after one year of service are detailed in the following presentation:

Background

On Dec. 21, 1974, Act No. 350 of the Public Acts of 1974 was approved by the Governor. This amendment to the Medical Examiner's Act provides for autopsy of children under two years of age who die under circumstances of sudden death. The primary purpose of this legislation is to assist parents in understanding why their child died, thereby reducing grief and guilt associated with sudden infant death. Secondarily, the autopsy reports could contribute to medical knowledge of the disease.

Act 350 was designed to provide autopsy at state expense, when parents or guardians so requested, in cases where the medical examiner has not already ordered an autopsy. In the course of his duties, the medical examiner need not have prior parental permission to perform an autopsy on medical examiner cases, since Act 350 clearly states:

> *Nothing in this section shall be construed as interfering with the duties and responsibilities of the county medical examiner as defined in other sections of this Act.*

The county continues to be financially responsible for medical examiner cases where autopsy is ordered according to other provisions of the Medical Examiner Act.

If the sudden death of an infant under two years of age is reported, and the examiner decides in the course of investigation not to do on autopsy, he . . . *shall inform the parents or legal guardians of the child that they may request an autopsy performed on the child, the costs of which shall be borne by the state.*

When an autopsy is requested by parents or guardians under the provisions of Act 350, it . . . *shall be arranged for by the county medical examiner and the parents or legal* *guardians shall be promptly notified of the results of that autopsy.*

Act 350 carries with it appropriations to pay for autopsies on cases of sudden infant deaths not now provided by Michigan counties. This would amount to between 80 and 100 of the 350 expected cases of SIDS in 1976.

Methods

The Michigan Department of Public Health was asked to administer the payment provisions of Act 350. In order to receive reimbursement, the medical examiner must:

1. Obtain a signed Request for Autopsy from the parents or legal guardians.

2. Perform or arrange for an autopsy which includes a complete external and internal examination including, but not limited to, gross and microscopic examination of the brain, inner ears, organs of the neck, thorax, abdomen and pelvis. Bacterial and toxicologic studies are done when judged necessary by the examining pathologist.

3. Obtain a complete Invoice-Sudden Infant Death Autopsy Form signed by the vendor of the service (e.g. private pathologist, hospital, county medical examiner) and certified by the county medical examiner.

4. Submit the Request for Autopsy form and billing invoice accompanied by the complete autopsy report to the

Michigan Department of Public Health
Bureau of Personal Health Services
3500 North Logan Street
Lansing, Michigan 48914

Payment of reasonable and customary charges will then be remitted to the vendor.

Results

The State of Michigan paid for 130 autopsies during 1975. Sudden Infant Death Syndrome accounted for 75 percent of the deaths reported under Act 350.

It is not known how many additional autopsies were performed at county or private expense. In 1974, however, before Act 350 took effect, there were 259 reported SIDS deaths. Of this group, 174 (67%) were autopsied and the results used to establish the cause of death as SIDS.

The large majority of cases autopsied under Act 350 were in the one to four-month age bracket. The same general age distribution was also seen among the 259 SIDS cases reported in 1974. In that year, eight of 10 occurrences were in the one-to-four-month age group.

Possibly due to the small sample size, the distribution of infant deaths autopsied under Act 350 is relatively equal with regard to race and sex. It is recognized, however, that black in-

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Mr. Taylor is coordinator of the Perinatal Intensive Care Program for the Michigan Department of Public Health.

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fants account for a larger number of State-supported autopsies than their relative numbers in the population.

The 1974 data, however, showed the expected trend, with males accounting for 60 percent of the SIDS deaths.*

Discussion

The 98 cases of SIDS represent 75 percent of infant deaths which were autopsied under Act 350. Since approximately 350 SIDS cases were expected in 1975, less than one of three were autopsied at state expense. Undoubtedly many counties are routinely performing such autopsies. The reporting of SIDS on death certificates, however, lags behind incidence predictions. In 1974, for example, of a projected 350 SIDS deaths, only 259 were reported on death certificates. There may still be a reluctance on the part of physicians to designate SIDS as a cause of death, especially when an autopsy is not conducted.

Parents who suffer the unexpected loss of an infant may be burdened with strong feelings of guilt and anxiety which can be allayed by compassion for the family and the rapid provision of information and counseling. Guilt can be tragically compounded by the direct or implied blame by friends, family or authorities. This is especially true in cases where a SIDS death occurs in a low socio-economic family or family which has other identified problems.[12] It is important in these cases that a diagnosis of sudden death not be undergirded by a fear of "missing a case of infanticide."

The parents should immediately be given the results of the autopsy including a diagnosis of SIDS by the medical examiner or family physician. The medical examiner should also notify the county health department that a SID occurred. Where the gross autopsy reveals no cause of death, an initial diagnosis of SIDS is useful to initiate arrangements for counseling. It is important for the family to learn immediately that the death is not their fault, before patterns of self-blame begin.

Follow-up contacts with the family are very useful. Some health departments are offering counseling services for SIDS parents. Home visits should begin as soon as possible after the infant's death and continue as long as the need exists. Communication between the medical examiner's office and health departments must be prompt to insure the success of a counseling program. It is a practice of some physicians when relating the autopsy findings to the parents, also to tell the family a public health nurse will visit. Hospital social workers also constitute an immediate crisis-oriented counseling resource which should be used.

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in 1974 the following number of SIDS deaths were reported: white males (100); black males (56); white females (53); black females (49); other female (1).

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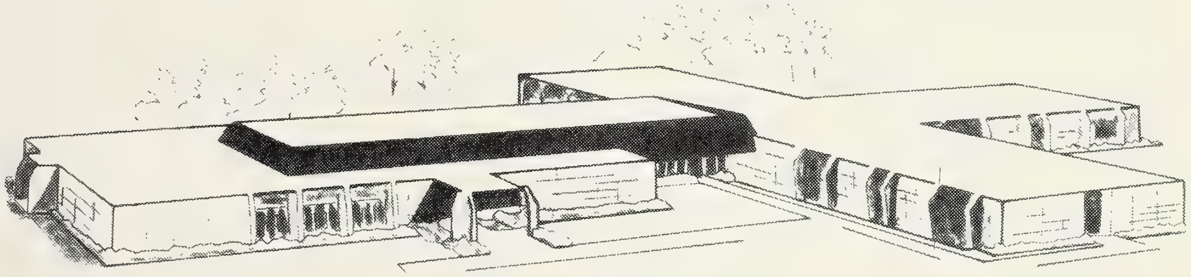

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feature

The Right to a Natural Death

By Joseph E. Kincaid, MD, FACP, Kalamazoo

"The right to die" is fast becoming a household phrase with recent cases, such as Karen Quinlan's, acting as stimuli for numerous newspaper and magazine articles and television programs featuring this concept.

"The right to die" concept, as presently used, means allowing death to come naturally to those with fatal illnesses, without using or continuing the use of extraordinary and inappropriate methods of treatment which only prolong the act of dying rather than restoring or improving the health of the individual.

When death is inevitable and the dying process has begun, the patient should be allowed to die in a dignified manner freed from the death-prolonging machinery. The family and friends should be at the bedside and not sequestered in an intensive care waiting room. The right of the dying to refuse non-curative, death-prolonging therapies should be respected.

The alternatives lie at the extremes of patient care: prolonging life at any cost or termination of that hopelessly ill life through euthanasia. Just as the living have a right to life, the dying have the right to die a natural death.

There is much haziness in our minds concerning this concept as witnessed by the various terminologies used to embody it. The phrase "death with dignity" comes close to expressing the concept. However, some euthanasia advocates have attempted to include true euthanasia under this term. Two "death with dignity" legislative bills of 1975 actually contained euthanasia provisions. So one should raise the question as to what is meant when the term "death with dignity" is used.

Not advocating a new synonym and yet searching for a phrase that encompasses the concept, this article will use the term "the right to a natural death."

The phrase has been altered from "the right to die" to include the words "a natural death" in order to exclude euthanasia from this concept. Euthanasia or mercy killing is the direct use of drugs or other medical modalities to deliberately cause the death of others for the apparent humanitarian reasons of bringing quick and painless death to those terminally or hopelessly ill.

Death is the immediate goal and intention of the act. Whereas, in the right to a natural death concept, a decision is made not to intervene in the natural process of dying.

With the dictum "Thou Shalt Not Kill" acting as the backbone, classical Judeo-Christian morality has ruled against euthanasia. A corollary to this tenet has been the belief that one need only use ordinary means and not extraordinary means to preserve and maintain one's body in this world in order for salvation in the next world. This corollary stayed on the theological "back burner" because, other than pilgrimages to curative holy shrines or the obtaining of rare, expensive therapeutic herbs, extraordinary means were scarce until modern medicine and its avalanche of available techniques brought this concept to the forefront of our present day concerns.

By 1957 Pope Pius XII felt it necessary to re-emphasize this principle in an address before the International Congress of Anesthesiologists:

"... Man (and whoever is entrusted with the task of taking care of his fellow man) has the right and duty in the case of serious illness to take the necessary treatment for the preservation of life and health ... But normally one is held to use only ordinary means — according to the circumstances of persons, places, times and cultures — that is to say, means that do not involve any great burden for oneself or another ..."

Medical ethics consistently has supported the right to die a natural death while condemning euthanasia.

In recent years these concepts have been increasingly challenged by sectors of society including the medical profession, so that the AMA House of Delegates at its December, 1973 meeting found it necessary to restate:

"The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family."

No Michigan legislation yet

At present, there is no legislation pending in Michigan regarding the proper time or circumstances of death. Among legislators interested, however, is Rep. David Hollister, D-Lansing, who has contacted educators, physicians and clergymen. His office has circulated drafts of legislative ideas on the subject and asked for response. Those contacted so far have been enthusiastic, his staff reports, and others have asked to be included in the discussions. *Michigan Medicine* and *Medigram* will continue to keep MSMS members informed.

Moving to the consideration of euthanasia, this same body stated:

"The intentional termination of the life of one human being by another — mercy killing — is contrary to that for which the medical profession stands, and is contrary to the policy of the American Medical Association."

Medicine Finds Issue Difficult

This clear counsel from the AMA notwithstanding, the medical profession seems to find it increasingly difficult to apply this concept of the right to die a natural death to the dying patient. The great advances of modern medicine have given physicians many more methods of helping the sick.

One danger in this sophisticated medical technology is that while there is a greater chance of curing the disease, there is also the greater risk of neglecting the total patient and the rights of the patient.

The science of medicine tends to race ahead of the art of medicine. This is frequently expressed as "medical care for the ill has become dehumanized by our advanced medical technology." However, technology can never dehumanize anybody; only human beings can dehumanize other human beings.

As young physicians are trained with emphasis on improving the cure ratio, the more basic goal of the physician is easily lost sight of; that is, to cure sometimes, to relieve often and to comfort always. As cure rates improve, some physicians may regard the death of a patient as a defeat, as a personal affront, or as an indication that the physician should have used other avenues of therapy or additional modalities.

Another barrier to a physician's desire to allow death to come naturally may be our present medical malpractice situation. A physician may feel that the best way to protect himself against a malpractice suit is to use all available medical therapies to effect a cure of his patient. He can then turn to the next of kin, assuring them and himself that everything humanly possible was done.

However, the use of all available medical technology does not necessarily mean that this technology was necessary or appropriate for the particular situation or that the patient's and the family's desires and rights were included in this attempt to obtain a cure at all costs.

Doctor Kincaid

An additional drawback to advocating the right to a natural death can be the present threat of judicial decisions and legislative bills touching on the subject. Will Judge Muir's verdict in the Quinlan case frighten physicians away from stopping other respirators in hopeless and irreversible situations?

Making the Decision

Who makes the decision, in the individual case, to invoke the right to die a natural death? The obvious answer would seem to be that the patient has the first choice to decide whether extraordinary or ordinary means will be used to sustain his life. The second choice rests with the family who becomes involved in the decision-making through the invitation of the patient or becomes the primary decision maker if the patient is unable or incompetent to do so.

However, this judgment is too overwhelming and the required medical knowledge is not available for any but the most exceptional patient or family to make this decision alone.

This vacuum must be filled by the physician furnishing the needed medical opinion and advice. In turn, the physician should be able to consult colleagues with expertise in specialized areas including the art of counseling the dying. A dedicated hospital medical-moral committee may fulfill this need. The decision should be retained within the classical, warm and compassionate patient-family-doctor relationship with a minimum of outside legislation.

Although a concept is easily understood, its practical application may be very difficult. As stated by Franz J. Ingelfinger, MD, Editor of the New England Journal of Medicine, "As there are few atheists in foxholes, there tend to be few absolutists at the bedside."

What criteria should the physician use to decide when death should be allowed to come naturally?

A primary consideration is whether the treatment offers a reasonable hope of benefit. There should be a sufficient chance for restoration of health or return to a semblance of normalcy to justify the efforts that will need to be undertaken. The terms "reasonable" and "sufficient" are knowingly vague but are within the province of the patient, family and physician to decide.

An accompanying criteria is whether the modality being considered is extraordinary or ordinary. Extraordinary would include all medical procedures obtainable only through excessive danger, pain, cost or inconvenience; or which if used would not offer a reasonable hope of benefit or the benefits expected would not be proportionate to the difficulties involved in obtaining that modality.

Admittedly the terms "extraordinary" and "ordinary" are relative terms, vary from time to time and are tempered by factors such as coexistent medical problems, age of patient, ease and cost of obtaining the special treatment and individual responsibilities.

Doctor Kincaid is an internist in private practice, chief of medicine at Borgess Hospital, Kalamazoo and assistant clinical professor with Michigan State University College of Human Medicine.

Some attempts have been made to bring other practical guidelines to the bedside to help decide when death should be allowed to come naturally. All of these guidelines can offer some support to the physician in the difficult counsel to the patient and family as to whether the life-prolonging therapies have a reasonable chance of reversing the death producing disease entities.

The decision whether to allow death to come naturally to the dying patient does involve the quality of life obtainable if extraordinary measures were to be used. However, "quality of life" has become a rather pat phrase and its application by some euthanasiasts has destructive possibilities. "Quality of life" has been suggested as a means of distinguishing personhood from mere biological existence.

If "quality of life" is based on such abstractions, their application at the bedside does not clarify the decision to permit death to come naturally, and in fact may be destructive and dangerous. So the "quality of life" solution must be carefully scrutinized before applied at the bedside of the dying patient.

The Quinlan Case

Turning to the Quinlan case, was Judge Muir's ruling right or wrong? That moral and medical decision can only be made at Karen Quinlan's bedside.

Several questions have not been answered by the reports in the news media. For example, if the respirator were stopped would respirations cease totally and permanently or would respirations continue but at a suboptimal rate decreasing the lung function tests and blood gases below the level that physicians and inhalation therapists have been trained to accept as good care?

Also, during the trial no physician testified that there was no hope for Karen Quinlan if she was given enough time and treatment. So are there medical facts to the case that the general public is not aware of?

However, we are not at the bedside in New Jersey. Basing one's decision on the reports in the news media and on the philosophy and guidelines concerning the right to die a natural death, as outlined earlier in this paper, one can conclude that stopping the respirator would not violate traditional moral or ethical tenets.

It is not within the scope of this paper to dissect Judge Muir's 48-page decision. But in summary, his ruling equated stopping the respirator with homicide. In fairness to Judge Muir, this may have been the only possible decision for him under the New Jersey law.

However, we have the curious twist here that something that is moral and ethical is at the same time illegal. This graphically points out the difference that will need to be resolved when the disciplines of law, medicine and theology meet for the much needed discourses to reach agreement on these "right to die" issues. Hopefully this agreement can be arrived at with a minimum of legislation and bureaucracy.

Opposing Right to Die

Other reasons have been offered for opposing the right to die a natural death. Instances are given where individuals have lain in apparent irreversible coma only to return to adequate functioning after months or years of advanced medical technology. Again a return to the bedside is necessary to see if there were not telltale signs of the eventual reversibility throughout the period of heroic medical care.

Near miracles and apparent medical miracles still occur and can happen with or without the use of medical technology such as respirators. Because of these occasional miraculous medical recoveries, are all medically judged irreversible coma cases condemned to a respirator until the heart or other organs play out resulting in the inevitable death?

Others fear the philosophy of the right to die a natural death because it may be "the wedge" or the "slippery slope" in the moral domino theory, as discussed by Cassen, leading to euthanasia. There is foundation for these fears.

So here lies the danger, that in our haste to assure a dignified death for the dying, that we mistakenly confuse the moral and ethical distinctions between active and passive euthanasia. When the philosophy behind it is understood, no one should fear that the right to a natural death will lead to euthanasia.

U.S. vital statistics improve

Americans' health continues to improve. Lower infant death rates and longer life expectancy are shown in a State of the Union's Health Report for 1975 submitted to Congress and President Ford by HEW.

Rates of infant deaths in the U.S. declined from 29.2 per 1,000 live births in 1950 to an estimated 16.5 in 1974. Over the same period, life expectancy at birth increased by nearly four years. The death rate for heart disease is decreasing.

The report, "Health, United States, 1975," includes data on health costs and financing, health resources and utilization, and health status. The death rate for heart disease among persons aged 55-64 dropped almost 15 percent over the past six years. In the same age group, the death rate from cancer rose almost four percent. Among younger persons, accidents and homicide are major causes of death.

In fact, an appreciation of the right to die a natural death can act as a buttress against the acceptance of euthanasia. The appeal of euthanasia speaks to the present tendency of the technology of caring for the living to drift away from the compassionate caring for the dying. Euthanasia is a negative approach to death and is an admission of defeat in caring for the dying. Euthanasia will not be sought if we will free death from the loneliness, desolation, pain, feeling of unwantedness and meaninglessness that so often accompanies death and dying.

Much to be Done

However, much must be done if we are to have a new and revitalized approached toward death. First of all, our vocabulary concerning death needs revision. The words "vegetable," "vegetative state" and "fetal position," when used to describe the dying person, are not helpful in developing a positive approach to death. Also the phrase "hopeless case" should never be regarded as synonymous with "meaningless life." Life and death always have meaning and purpose. The meaning of death may be sought simply as a time for an individual to inventory his stewardship with his Creator and a time of preparation for the Hereafter.

Caring for the dying may be much more demanding on physicians than the skill needed in using medical technology in caring for the living. When the decision is made to cease extraordinary measures and forego heroic modalities, total care of the dying patient demands that extraordinary concern and heroic compassion continue until death. The physician may face his greatest challenge after the decision has been made to stop extraordinary measures, in helping prepare the patient and the family for death.

As the living have the right to life so have the dying the right to a natural death. A prime measure of our humanity is the priority that we place upon respecting these rights.

(References available from author.)

The Lethal State

By Emanuel Tanay, MD
Detroit

On July 3, 1973, the *New York Times* in an editorial stated:

"It is no great secret that euthanasia is frequently practiced here and abroad. Normally, this takes the form of cessation of 'extraordinary measures' when all reasonable hope seems gone; it is a decision, for example, not to put the comatose patient in a respirator when he develops breathing difficulties. But even such a passive response to the problem involves the physician in subjective judgment on the probability of recovery that should not be left to one individual

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acting alone. In any event, practice varies widely from case to case, doctor to doctor, and hospital to hospital. 'Unofficial' euthanasia is obviously open to abuse, since it is normally perceived for what it is and unreviewed by independent parties. Dr. Malcolm C. Todd, President-Elect of the American Medical Association, is quite correct in arguing that physicians should not have to make the decision on mercy killings — even if they are merely decisions to refrain from medical intervention — by themselves. He suggests that boards made of diverse kinds of people make the needed determination."

The New York Times in its editorial supported the proposal of Doctor Todd. On November 11, 1975 the *Times* in a front-page article reported:

"Judge Robert Muir, Jr. today refused to authorize the removal of the respirator sustaining the life of Karen N. Quinlan, saying the decision was a medical one and noting that the woman's attending physicians were opposed to disconnecting the machine."

It is, indeed, too much of a burden upon the individual physician to take upon himself the awesome responsibility of terminating the semblance of life which exists in individuals who can never again recover. Judge Muir not only failed to take cognizance of the new state of affairs created by development of medical science, but he added to the confusion by his claim that the decision is a medical one.

Nothing could be further from the truth than the claim that his decision was based upon the recognition "that such decisions are essentially medical rather than legal," as Doctor Max H. Parrott, president of the American Medical Association, would have us believe.

One has only to ask the simple question: What would happen if the medical decision was in favor of discontinuation of the extraordinary supportive measures required? Judge Muir gives a clear answer to this question in his decision:

"And, although he recognized the primacy of the physician's judgment in making decisions, such as those affecting Ms. Quinlan's life, Judge Muir indicated that removal of the respirator might have violated State homicide statutes, as was argued by William F. Hyland, State Attorney General, and Donald G. Collester, Jr., Morris County Prosecutor." (*New York Times*, p. 54)

He then went on to say that under New Jersey law:

"The intentional taking of another's life, regardless of motive, is sufficient grounds for conviction . . ."

In other words, *the decision is a medical one, provided that the doctors are willing to assume the burden of being charged with homicide, which does, indeed, limit the decision making.*

Supremacy of Legality

The Quinlan case is another example of the supremacy of legal principles over reality. A similar area is that of commitment proceedings, where concern with legal consistency and legal principles overrides the demands of reality and medical needs of the patient.

The law is still involved with the old issue of euthanasia and fails to recognize that we are facing now an entirely different set of circumstances. In the past, euthanasia meant a mercy death for someone who was incurably ill and was about to die in the immediately foreseeable future. Euthanasia is an externally induced death by administration of large amounts of morphine or similar substance.

The new problem arises out of the fact that medical science artificially maintains an aspect of life when there is no reasonable hope that independent life can be resumed by the individual. Since the maintenance of such vegetative states imposes suffering upon the living without accomplishing anything for the individual in the vegetative state, common sense and medical ethics impose upon the physician a temptation, if not an obligation, to terminate this most unhealthy situation.

The failure to differentiate between putting to death and letting die imposes upon relatives and physicians of the patient who is in a vegetative state an intolerable burden.

The question should be asked: Who benefits from the fact that some people are denied the right to die? For whose sake are we condemning some people to incomplete death?

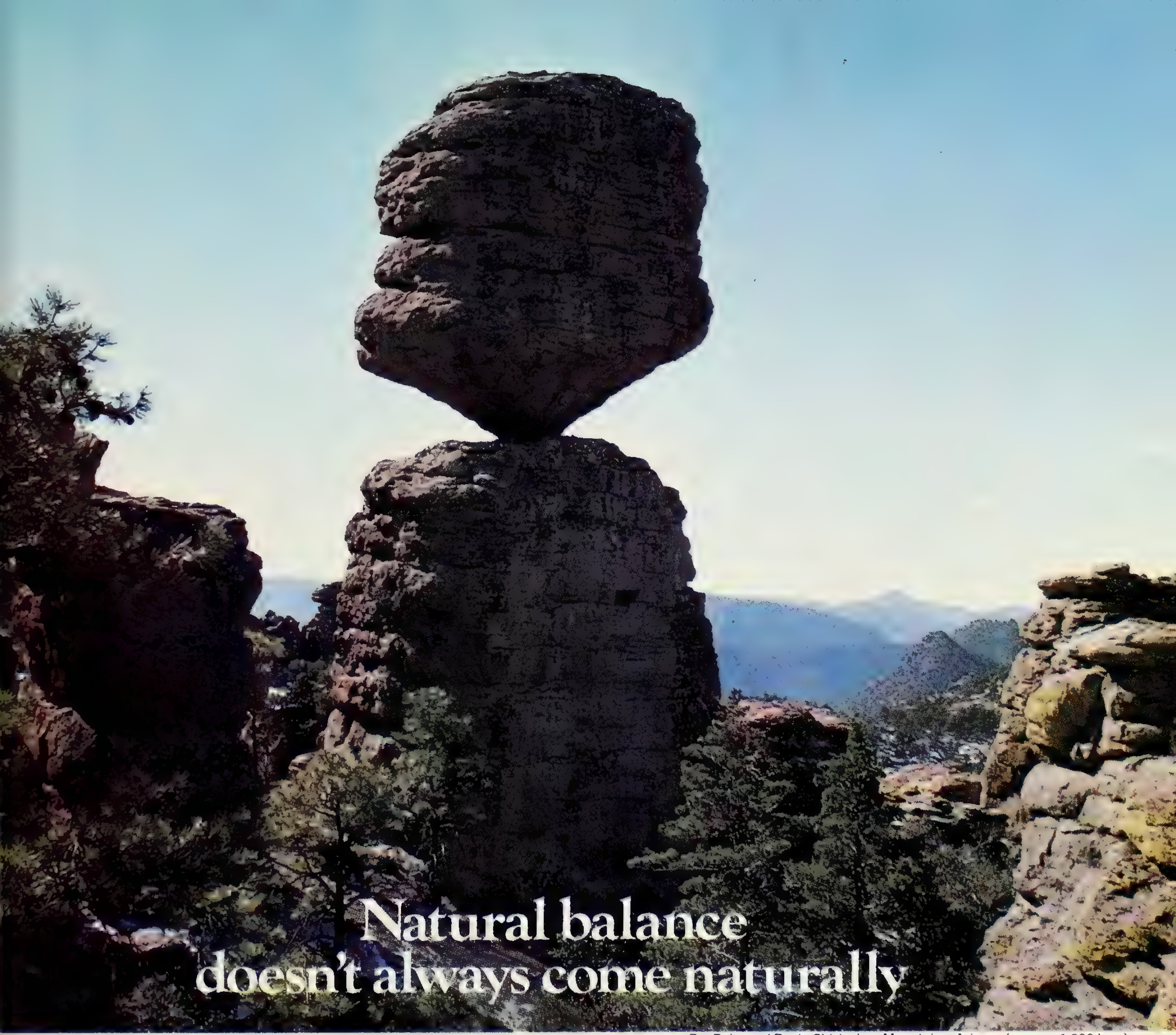
It appears to me that we are merely preserving the consistency of the legal structure. We are slowly but inexorably moving towards the four generation civilization, namely, the young, the middle-aged, the old, and the half-dead. To die with dignity is the right of a human being just as much as the right to live in dignity.

Call It 'Lethal State'

There is, indeed, a need to define the term "life." We have instead attempted to define death. Aquinas defines a life being "insofar as it operates of itself and not as moved by another." We need a term describing a form of existence which is neither life nor death, since science has created a form of existence which is neither death nor life. This new form of life cycle, this transitional phase could be simply called lethal state. This can be defined as presence of some vital functions without the significant likelihood of return of all essential vital functions.

Modern science and technology create problems which the modern jurisprudence has to meet. We have altered the nature of life and death. We can now maintain life in an incomplete state indefinitely. Freud said: ". . . it is a truth that knows no exception that everything living dies for internal reasons." (Vol. 18, p. 38) Science has created a state where it is possible for life to be maintained for external reasons. The time dimension of the process known as dying has been expanded from minutes or hours to weeks, months, and at times even years. This lethal phase of life can be extended until ultimately sufficient technology will be developed to maintain such a state indefinitely. It is possible to avoid facing the issue of termination of the lethal state as long as technology limits the application. When the "lethal state" population will reach significant numbers and extend over a significant period of time, we will be forced to come to terms with this issue.

(Doctor Tanay is associate professor of psychiatry and law at Wayne State University School of Medicine.)



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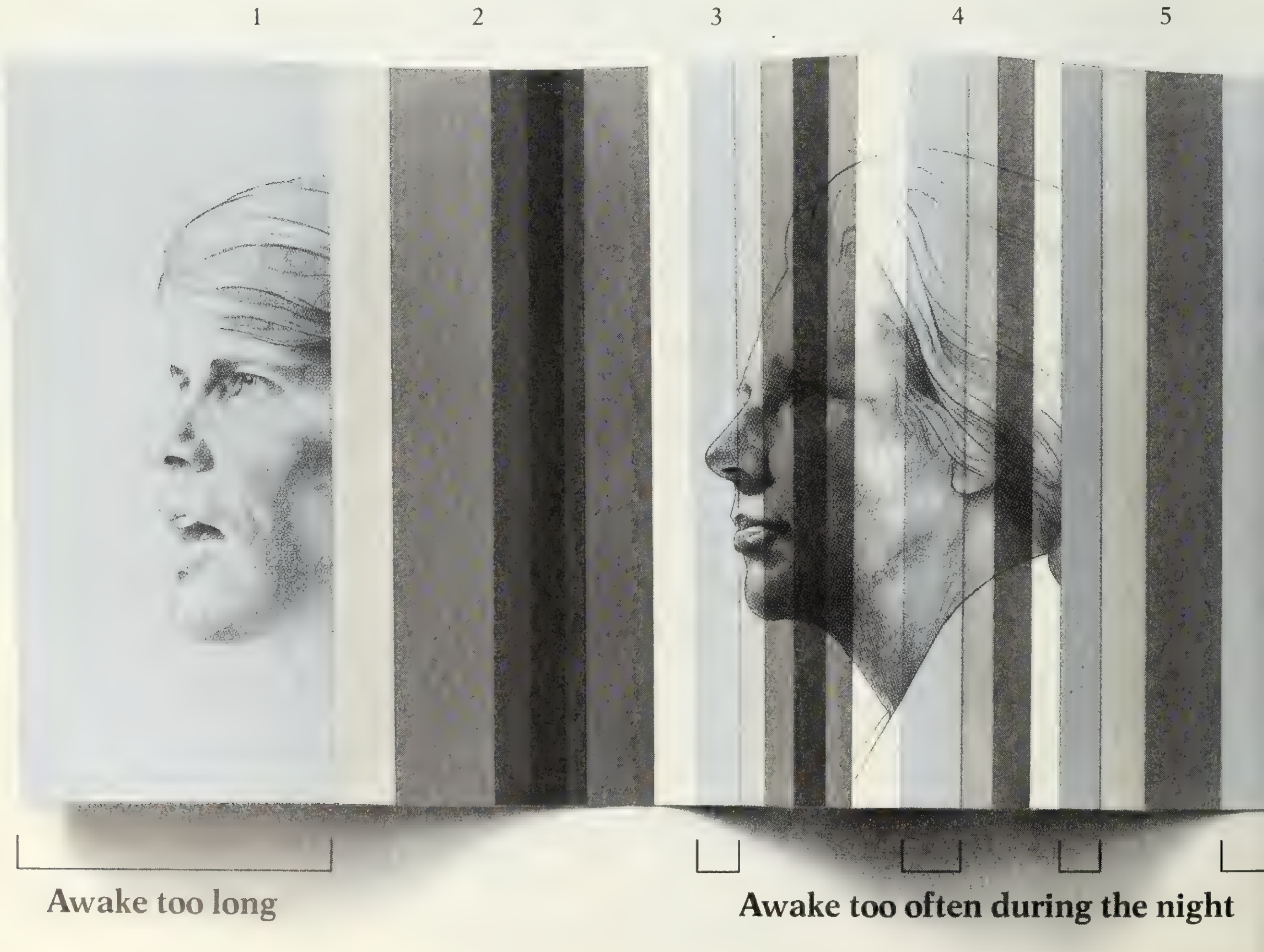
Sleep Stages

▢ Awake	▩ Stage 2
□ REM	▦ Stage 3
▢ Stage 1	■ Stage 4



Awake too long

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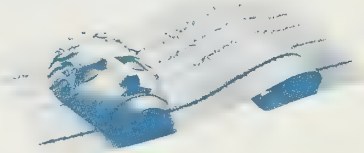

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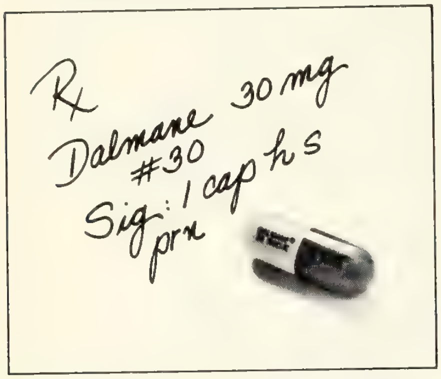
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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commentary

Blues at impasse with providers; their philosophy must change

By Glenn E. Moore, MD
Flint

The present Michigan Blue Shield/ Blue Cross "service" contract is an anachronism. It is like the sailor with one foot on the dock and the other on the departing boat. Faced with constant and increasing pressure from providers, unions, big business, individual subscribers and the insurance commissioner, the Blues, like the sailor, must make a decision.

The importance of health insurance is evident, and there is no doubt that the services covered by our contracts in Michigan cannot be exceeded anywhere in the country.

The Blues have been very successful.

One of the reasons is the high percentage of premium income which is returned to the subscriber in services. The Blues have been able to do this because the bulk of the paper work which is necessitated by their far-reaching programs has been carried out by the providers. All providers are acutely aware of the high overhead expense incurred by the production of computer consumable records, which the Blues then utilize at a minimum of expense to themselves.

However, the system is in serious trouble now. A break-down point has been reached — the insurance company has to run in the red to pay for services; the provider can no longer absorb cost-containment policies of the Blues; and the individual and industrial subscriber can no longer afford the premiums. The Blues are restricted by the insurance commissioner in how quickly and how much they can raise premiums. At the same time, the providers are faced with constantly spiraling costs (the greatest of which is malpractice), and it is unrealistic for the Blues to think that the providers can continue to absorb rising costs of doing business on a restricted income.

We are at an impasse. There may soon come a day when the provider will refuse to accept the Blues cost-containment efforts and say to the patient, "I will provide the service, but *you* must pay me for it and then *you* collect from your insurance company."

Sometimes, people working on boards or committees, without realizing it, assume Jekyl and Hyde personalities and become impractical in their zeal to do good. No matter how fine their intentions, the Blues do their subscribers a disservice when they harrass providers to the point of rebellion.

The Blues are trying to do what is bankrupting many federal medical systems around the world. There is no practical limit put on the demand for medical services, and if you undertake to supply them all on a fixed income, disaster results.

What the governments and the Blues must come to know is that **providers** cannot control utilization in our present socio-economic-legal milieu. When a patient presents himself for care, doctors and hospitals are **obliged** to render complete care which satisfies not only good **medical** practice but also satisfies the **patient's** concept of good care. This frequently means unneeded X-Rays, lab tests or hospitalization. If you deny this is happening, you are unaware of the medical facts of life today.

Let this point be reiterated — providers have no desire to destroy the Blues. But some changes must be made. There are solutions, and one might be an **indemnity** type contract, renewed annually. For the premium dollar received, a fixed amount and variety of services would be provided. Both the provider and the premium payer would know the limits within which they must function. A contract written in January would not be expected to cover new procedures added to the medical armamentarium in the following July. The annual revision would allow adjustments in services and costs. The premiums should be validated without delay by the insurance commissioner. Policies should be tailored to the needs of the family with resultant savings over a blanket-type coverage. This would be especially helpful to the person who does not receive Blue Cross as a tax-free fringe benefit but must pay for it himself. If costs rise above the amount allowed by the insurance company, the recipient of the service — i.e., the patient, must pay the difference. This takes the pressure off the Blues to be constantly imposing cost-containment programs on providers.

Another option is the **deductible** type policy. The Blues have offered

Doctor Moore

Doctor Moore is immediate past coordinator of the Michigan Council of Specialty Societies.

DOCTOR MOORE/Continued

this before and it has not met with widespread acceptance. The reasons seem obvious — there was no real premium-savings and the company did not promote the idea with any real vigor. However, the federal government realized this need when they made Medicare a deductible type coverage. It might be worth an honest effort.

The Blues are in an unfortunate situation — caught between a politically oriented insurance commissioner and a cost-conscious business community which bears much of the burden of the premium dollar. A change in philosophy is needed by the governing bodies of the Blues to bring into permanent alignment expenditures and income without wringing the life out of providers or robbing subscribers of essential services.

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(That message was timely when it appeared in the MSMS Journal in 1925 – 50 years ago – and it is equally timely now – the Editor.)

Compulsory CME: Will it be Effective?

By Robert B. Carbeck, MD
Ann Arbor

The recently enacted legislation making documented continuing medical education (CME) a requirement for licensure in Michigan, has created many questions in the minds of practicing physicians. Through activities at the hospital level, state level, and national level, I have been involved in discussions regarding many facets of this new phenomenon. The details of the regulations have been well outlined and documents sent to all members by MSMS. Other aspects are not as well outlined and it is these I would like to discuss, confining my comments to in-hospital programs.

"How will accumulating "brownie points" make me a better doctor?" It won't, necessarily. Those physicians who wish to circumvent the intention of the law will probably be able to do so. They will sign in and leave after five or ten minutes, will sleep or read Playboy during the programs, etc. If the programs are really relevant to their practice and are presented in an interesting fashion, most physicians will remain, both mentally and physically, throughout the program. Those who consistently fail to do so, and who do not educate themselves through other means, will be detected by medical audit.

"O.K., I'll attend but the conferences are never about anything I see or do." The opposite view to this is held by those who feel CME should really be aimed at keeping them up with what's new from the research laboratories and tertiary care centers. Actually, this is not an either-or situation. New findings can be included in a program dealing with a common problem. Yesterday, our weekly medicine conference involved alpha-1-antirypsin deficiency. However, the major educational objective of the conference was the optimal evaluation of patients with recurrent lower respiratory tract infections. Alpha-1-antirypsin deficiency was included, the biochemistry and pathophysiology were described and then the relevance of the syndrome to the management of patients with recurrent lower respiratory tract infections was discussed. Something for the scholar in all of us; something for the pragmatist in all of us.

"What's all this about programs being based on the needs of the learner?" The most important single factor in learning is motivation. Many, such as Dr. George Miller[1] and Bob Mager[2] equate teaching and motivation. Motivation can be translated into "need to know." We learn those things which we feel we need to know or which we are shown that we need to know. One example of the latter is the Death & Complications conference which all hospitals have been having for years, and which are required for accreditation by the Joint Commission on Accreditation of Hospitals. Another example is medical audit. In the former category, perceived needs, the most common example is one in which we are faced with a patient with a certain medical problem and find ourselves unsure as to its optimal management. For practicing physicians, this is the most effective motivation.

"Isn't that post-program evaluation just a waste of time, paper, and space?" Often it is, but it doesn't need to be. If the program is based on the results of medical audit, then re-auditing of the group performance after the program is an ideal evaluation mechanism.[3] This should be done, when possible, and hopefully will be a more frequent occurrence. Most of our in-hospital programs, however, are not based on medical audits. How then can we evaluate these programs? A short questionnaire can be handed out at the beginning of the conference and collected at the end. Questions we have found helpful to include in such an evaluation form are (1) were the educational objectives of this meeting clearly stated; (2) were the educational objectives,

as stated, well covered in the presentations; (3) will you be able to use what you have learned in your practice; (4) was the level of presentation too simple; too sophisticated, or just right; (5) did you find the use of audio-visual aids effective; (6) what was your overall impression of the program; (7) how could the program have been improved. The responses to these questions can be extremely helpful in the development of subsequent programs.

These are but a few of the questions frequently asked by practicing physicians about continuing medical education. As we become more familiar with the "practice" of CME we will learn better how to achieve our educational objective, the delivery of optimal patient care by all of us who practice medicine.

Will mandatory CME be effective? Will our patients receive better care, have better outcomes, because of it? As with most other instruments, the effect depends largely on the user.

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Doctor Carbeck is president, Michigan Association for Medical Education (MAME).

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Legislation aimed at addiction must support prevention

By Joseph T. Sobota, MD
Kalamazoo

The following is an edited version of a "letter to the editor" which appeared in a recent issue of the ***Kalamazoo Gazette****.*

The six bills aimed at the "large volume heroin dealer" and, by implication, the "heroin problem," recently approved by the Michigan House Judiciary Committee and sent to the House floor for consideration miss the mark. In fact, the proposed bills will slow efforts to understand heroin addiction by deflecting funds into law enforcement agencies rather than research, therapy, prevention and education.

Don't get me wrong; I'm interested in sending as many heroin dealers to jail as possible, but many laws directed against them already exist. The content of the proposed bills reflects utter ignorance of the dynamics of heroin addiction and the general problem of addiction to other abused chemicals.

The proposed legislation also fails to recognize or misinterprets the reasons for the abysmal record of law enforcement to curb import, and obtain dealer convictions. The additional tool given law enforcement agencies by these bills is the legalization of electronic wire tapping, a technique potentially prone to more misuse than any known drug.

Proposed Laws Futile

The practical futility of the proposed legislation is exposed upon analysis of the characteristics of heroin addiction, experience with alcohol, the past record of law enforcement efforts and the realistic impact of electronic wire tapping.

No one develops a heroin habit by casual contact. An individual has to use a street drug three to four times a day consecutively for three to six months to become a true physical addict. Only individuals who are physically addicted need the drug to keep them from becoming sick.

Seventeen percent of a well-studied student population reported that they used heroin once. One percent of this group used the drug more than once. A minute fraction of individuals who used heroin more than once went on to physical addiction. Heroin addiction is a complicated disease and is not simply associated with the availability of the drug by any number of heroin dealers. Licking the heroin problem is not synonymous with licking the heroin dealer.

It is unreasonable to provide law enforcement agencies and courts with laws which cannot be effectively enforced or tend to undermine basic constitutional guarantees. There should be no letup by law enforcement agencies to apprehend drug criminals. However, an increase of police action and drug dealer penalties will not meet expectations for a "heroin problem" cure based on past experience with heroin or, for that matter, alcohol.

Some Alternatives

A legitimate requirement of legislation is the appropriate direction of resources to programs which promise the greatest return. Instead of increasing our resource allocation to cover infinite heroin distribution conspiracies, we should look first for legislation to support research programs, therapy, education and prevention techniques.

In Kalamazoo, we only have 50 places for heroin addiction therapy in the Potter Program; yet, we have many more heroin addicts. We have no way of identifying early narcotic users and no funds to broaden our treatment modalities to include residential facilities, drug-free programs and the use of narcotic antagonists.

The education of the young and older population about the effects of mood-changing drugs has to be re-evaluated and improved. The effects of mood-altering drugs must be presented honestly and attention given to both legal and illegal agents.

Those afflicted with an addiction whether heroin, alcohol or other substances, require our help rather than punishment. Punitive action against individuals with addictive states generally drives them underground, creates a counter-culture and coerces individuals into crime for funds simply to prevent them from becoming sick. The price of treatment and research, I dare say, would equal that of law enforcement, but it holds the ultimate bonus of eliminating the basic cause for addiction and the associated crime infrastructure, including the heroin dealers.

Elimination of the heroin dealer and addict-initiated crime are goals we can all agree on. Legislation supporting therapy, research, education and prevention of addiction aim at the heart of those goals. The six bills introduced in the Legislature miss the mark badly.

Doctor Sobota

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How about MSMS members as public medical experts?

Doctor Margolis

By Frederick Margolis, MD, Kalamazoo
Member, MSMS Division on Public Service

What can the physicians of Michigan do through MSMS to increase the flow of accurate health information to the public, and how can we correct the misinformation that we see and hear every day from the media?

Every physician, I am sure, gets angry when he reads some phony advice in the newspapers . . . but few of us ever take time to correct the information. The next time the reporter needs some information, he looks in the newspaper files and the same bad information appears again.

I think all physicians are aware of the need, which was well documented in the article in the *New England Journal*, published from Wayne State, which surveyed the health related materials on television for a particular length of time and found that 70% of it was either inaccurate or in error.

Of course, where I really see it is in my pediatric practice where our patients are in a state of confusion and anxiety. Parents, for instance, see material in some newspapers that tells them fluoridation is going to cause their children to be mongoloid and that they are going to have soft bones and arteriosclerosis.

Recently a young lady who has no training in nutrition at all appeared with Barbara Walters, and related how infant foods will cause mongolism, that their salt content is dangerous and will cause hypertension and arteriosclerosis. The American Academy of Pediatrics actually got a tape of this material and corrected it — and got out the documentation from the National Nutrition Board and sent it to Barbara Walters. She invited one of our AAP members to appear and correct the misinformation.

The editor of our local paper said that when he has a legal question, he calls the Attorney General's office and gets a good opinion right away. But he said the press has no good source for information in health matters.

In any case, I find that I am spending time each day trying to correct the misinformation patients are getting through the media. Patients have no way of evaluating what they read. They have no way of knowing what is important and what is not important.

How can MSMS work to correct the problem?

May I suggest a program that could have involvement of a large number of MSMS members and could be a real service to the public as well as a creditable type of thing for the medical profession to do. The idea does need modifications and improvements in the event that we would want to tackle it.

MSMS would select from our medical schools, and the profession, perhaps 15 or 20 experts in the different medical fields. This blue-ribbon committee would be able to produce authoritative statements on health problems that would be made available to the television, press, and radio media. The public would begin to look for their expert opinions because they would be something that they could understand. Correct information can give a patient a sense of comfort and a sense of understanding of what is really going on. The MSMS panel of experts would counteract misinformation which comes out of the media these days.

The second role would be for the panel to write and originate a series of solid health information articles. MSMS could ask each of the panel members to write about some problem common to a large portion of the public.

Each of us in our own specialty could pick out a half dozen such subjects that need to be clarified.

MSMS could approach the same responsibility by releasing an article about the "myth of the month." In pediatrics alone, we could take many months to cover all the mythology.

The third area of this MSMS operation would be to identify MSMS as a clearing house for questions that the media have. Many editors are very responsible people and would like a resource to answer questions. I believe that if the media knew that there would be a reaction to misinformation and an outlet for meeting their informational needs, that we would get more responsible reporting and a greater awareness and interest in accurate reporting.

It is a fact, in my judgment, that we have been very negligent in filling the role that physicians and MSMS should appropriately take. That is to see that what we do know scientifically is presented to the public in a fashion that they can understand. It is high time we take the responsibility for providing these answers and productive material.

Doctor Margolis is an active member of the American Academy of Pediatrics and a nationally-recognized filmmaker who is producer of the 13 "Ounce of Prevention" film segments on children's illnesses which is currently being used around the country on public TV stations. The programs have been shown in Detroit and Grand Rapids and will be aired this month in Lansing.

What NHI cannot do for us, we must do for ourselves

By Richard I. Ecker, MD
Kalamazoo

As a first year post-graduate physician, I am no different than perhaps 14,000 other individuals at this point in my career. The question which confronts us all is: what can be done to significantly increase this thing which we call health and happiness here on earth?

In anticipation of 1976, my thoughts on this matter run to the attention and hope attached to national health insurance. All of the NHI plans are and will continue to be pushed for all they're worth in search of the elusive "good health" to which we feel we are entitled. One wonders if any of these plans does just that.

Narrowing our scope to just the morbidity/mortality question, and considering a few well known health statistics, we can see that the individual has a very large stake in this question.

Therefore, on the threshold of national insurance, we as Americans should clearly understand that though NHI may solve many problems of finance and health care delivery, we cannot expect it to dramatically decrease those diseases we as individuals heavily contribute to.

Furthermore, if one examines health care statistics of morbidity/mortality and also looks at what we know of American life-style in general, striking patterns appear which have long been noted by epidemiologists.

The single largest cause of death in this country is heart disease. Many contributing factors to this group of diseases are conspicuous in their relation to that thing we call "the American way of life."

Similarly, cigarette smoking is the most strongly established behavioral link to coronary artery disease. It is also emphatically linked to lung cancer by the Surgeon General and represents a large portion of the deaths of America's number two killer, cancer.

Surveying other causes of death which are prominent in this country, cirrhosis, the irreversible atrophy of the liver, ranks high. A large portion of these deaths can be attributed to behavioral linked problems such as alcoholism and hepatitis.

In the fight against disease, we are all our own worst enemies. More directly, what NHI cannot do for us, we must do for ourselves. NHI is not the pot of gold at the end of the health care rainbow.

(Commentary Continued page 226)

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Organized medicine must face issue of relicensure and assessment

By Louis R. Zako, MD
Member, Governor's Task Force on Health Personnel Licensure & Certification

The manner in which professions are licensed and regulated is currently under great scrutiny in Michigan. This is particularly true for persons in the health professions. State government is attempting, as never before, to assure consumers of professional competency and quality care. While this is a nationwide phenomenon, the movement is particularly vigorous in Michigan, where no less than six different bodies or task forces are taking a hard look at regulation through licensure or relicensure:

(1) The Public Health Statutes' Revision Project proposes an extensive report on professional and occupational licensure. (2) The State Health Planning Advisory Council has adopted eight recommendations to present to the Office of Health and Medical Affairs. (3) House Bill 4804, now in the legislative stage, would impose additional lay membership on the board and a review annually of each licensed physician. (4) The Governor's own Task Force on Occupational and Professional Licensure proposes changes. (5) The State Bureau of Management Sciences proposes extreme alterations in the Department of Licensing and Regulations systems review. (6) And Rep. Gary Owens' House Study Committee now is preparing its report on failures and oversights in the department.

The connecting threads running through all these reports are:

1. The consuming public shall have more voice on licensing boards.
2. Periodic reassessments of license holders for competency shall occur.
3. Complaints against practitioners must receive earlier and more careful scrutiny.
4. A variety of limitations on licenses, ranging from control mechanisms such as the Medical Practice Board's limited license to licensing by specialty, is being seriously considered.

Traditionally, professions have tended to "police their own." Medicine's quality control has been exemplary, as documented through the decades by medicine-sponsored licensing acts in the 19th Century, the Flexner Report in the early 20th Century, specialty society continuing educational requirements since the 1940's, AMA's Physician Recognition Award, hospital tissue and review committees, and many others. Probably no profession has so assiduously "policed" itself.

Nevertheless, society in the last two decades has severely questioned whether medicine, or any profession for that matter, can truly conduct its own quality control.

Demands for public membership on professional boards have been only partly satisfied by placing one such public member on each of Michigan's occupational and professional licensing boards. Further, the demand for excellence (or suspicion of something less than excellence) by the consumer movement, coupled with the public's general lack of knowledge and sophistication, has placed undue emphasis on specialty designation of physicians. Now there are more and more frequent proposals being heard to license physicians by specialty designation.

The impact of consumerism on licensing and regulation can be expected to continue and to expand. Indeed, one current recommendation before the Governor (Management Sciences) proposes that the Department of Licensing and Regulation be retitled the Department of Licensing and Consumer Affairs, a recommendation with a good likelihood of being adopted.

Perhaps of primary importance now is that organized medicine squarely face the issue of relicensure and assessment of continuing competence. Following are eight recommendations on relicensure that have been acted upon favorably by the State Health Planning Advisory Council and forwarded to the Office of Health and Medical Affairs. Parenthetical comments indicate MSMS position.

Recommendation 1 — It is recommended that the boards in the Michigan Department of Licensing and Regulation which license

Doctor Zako

health-related professions study and develop within six years relicensure mechanisms based on continuing competence.

(MSMS supports the general intent of this six-year study, which responds to a legitimate public concern. However, our support should be qualified with amendments to this effect: " . . . that the boards in the Michigan Department of Licensing and Regulation which license health-related professions study ***the feasibility of relicensure mechanisms based on continuing competence, and report WITHIN six years.****)*

Recommendation 2 — It is recommended that the boards use the following guiding principles in establishing relicensure procedures:

a) consumers are provided with assurance that the state has reason to believe that all practitioners licensed possess minimal competence necessary to practice at an acceptable level;

b) the mechanism for relicensure should have a measurable relationship to performance in areas of actual day-to-day responsibilities of the practitioner; and

c) differences exist among licensed health professions which make it impossible to implement a single mechanism for all occupations, however, some comparability in relicensure should exist across all professions.

(This establishes guidelines for the proposed study and assures consumer access, and is supported.)

Recommendation 3 — It is recommended that each board establish a committee (to include public members, board members, practitioners and educators in the field) whose responsibility will be to research and recommend to the board mechanisms for relicensure. The tripartite committee's responsibilities shall include:

1) defining areas of practice and competencies needing relicensure,
2) matching areas and competencies to the most suitable mechanisms for measuring level of competence.
3) laying the groundwork for experimental programs to determine feasibility, effectiveness, and cost,
4) determining periodicity of relicensure process, and
5) recommending sources of payment for relicensure.

(This keeps the study well within the scope of the Board, which should continue under the State Constitution to be medically-oriented. The charge to the study committee is inclusive and is supported by MSMS.)

Recommendation 4 — It is recommended that the director of the Michigan Department of Licensing and Regulation be responsible for monitoring board developmental relicensure activities.

(This places monitoring correctly and is supported by MSMS.)

Recommendation 5 — It is recommended that relicensure committees consider development of a restricted licensure process when issuing sanctions to practitioners demonstrating unacceptable competence levels.

(So much misunderstanding of limited licensure, specialties and their role, and possible other constraints – to the detriment of the public – exists, that Recommendation 5 seems to be premature and damaging. MSMS opposes implementation of Recommendation 5.)

Recommendation 6 — It is recommended that legislation be passed to require all institutional health care providers to report to the appropriate licensing board dismissal or suspension of any health professional licensed by the state.

(Reporting of physician discipline by hospitals and professional societies now is a fact by law. MSMS supports this recommendation, but it is relatively meaningless.)

Recommendation 7 — It is recommended that the legislature place a moratorium on licensing any new health professions under a voluntary licensure law and provide for a review of all current statutes for voluntary licensure in order to determine the form or necessity for such statutes.

(The AMA and MSMS are on record supporting a moratorium for the next several years on licensing of new and expanding professions to allow more adequate study. MSMS supports Recommendation 7.)

Recommendation 8 — That implicit with each recommendation is a study of cost effectiveness to the general public.

(This wise additional recommendation will provide valuable insight into the worth of proposals emanating from the six-year study, and is vigorously supported by MSMS.)

"I don't like the sound of that motor."

'Malice in Blunderland'-type judicial reasoning scored

The following article is reprinted, with permission from a recent issue of the **Detroit Medical News.**

By Edward G. Tallant
Detroit

In a recent issue of the *Journal* of the Louisiana State Medical Society, F. Michael Smith, president of the Society, commented upon the medical malpractice situation. He quoted the following opinion of a concurring judge in a 1974 glaucoma case tried in Washington. He supported the findings for the plaintiff, in part, with the following words:

"There are many situations in which a careful person is held liable for an entirely reasonable mistake . . . in some cases the defendant may be held liable, although he is not only charged with no moral wrongdoing, but has not even departed in any way from a reasonable standard of intent or care . . . There is a strong and growing tendency, where there is blame on neither side, to ask, in view of the exigencies of social justice, who can best bear the loss and hence to shift the loss by creating liability where there has been no fault."

Read that one over again. It really means that if an unavoidable untoward result occurs, even if it is inherent in the nature of the procedure and you have done nothing wrong, someone is going to pay for the result, namely you and me.

This isn't justice, it's who should be the patsy, who can best come up with the money, who is in a better financial situation, the physician and his insurance carrier or the plaintiff.

Carrying this line of reasoning to its ultimate conclusion, then, any patient who can afford through his personal finances or his carrier to afford the financial loss should not sue while the financially deprived patient should collect regardless of the merits of the allegation.

This type of judicial reasoning, which could well be lifted from "Malice in Blunderland," is an important factor that has forced malpractice carriers to seek out of court settlements at high figures where no blame exists or they remove themselves from the malpractice field entirely.

I cannot see where this type of legal "reasoning" has any remote relationship with the concept I have held, that the courts are to administer *justice*.

Doctor Tallant

Mrs. Haidostian

Auxilians good resource for MDs

The following is excerpted from an address by Mrs. Berj H. Haidostian, WCMS Auxiliary president.

"Physicians in Wayne County, Michigan and the nation could use Auxiliary members to do the public relations job that the doctors have been unable to do for themselves . . . that is, we could go to the public, in our communities and do a person-to-person job of explaining our doctors' positions on malpractice insurance crisis, national health insurance, socialized medicine, etc.

"*But* we must first be informed, be educated, we must comprehend the issues — and then give the explanations to our lay friends.

"The Auxiliary needs every doctor's spouse as a member of the Auxiliary if for no other reason than because there *is* strength in numbers.

"The doctors should encourage their spouses to become members who would then receive the literature from the national and state auxiliaries that would keep them as informed as they would want to be on the current pressing medical issues."

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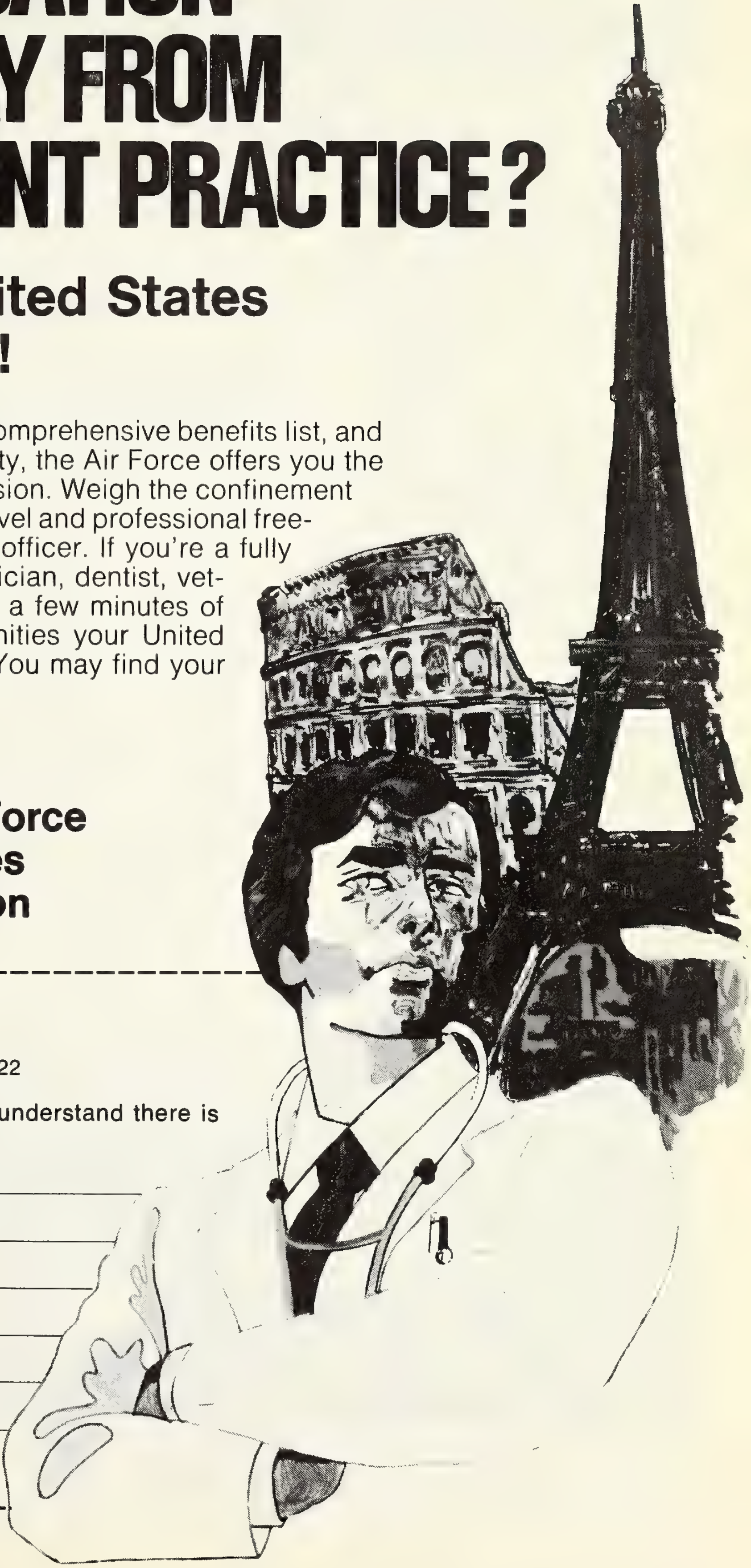

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Air Force Medicine

Hector Bensimon, MD, St. Joseph urologist, has been notified that his motion picture, "The Posterior Approach in Renoureteral Surgery" will be shown May 19 at the annual meeting of the American Urological Association. The movie was made at Memorial Hospital, St. Joseph.

* * *

Robert B. Carbeck, MD, Ann Arbor, head of the department of internal medicine at St. Joseph Mercy Hospital, Ann Arbor, is new vice president of the Association for Hospital Medical Education at the group's recent meeting in Chicago.

* * *

Larry E. Fleischmann, MD, and Franklin D. McDonald, MD, two WSU School of Medicine faculty members, are among five physicians honored by the Wayne County Chapter, Kidney Foundation of Michigan, for their kidney transplant activities. Doctor Fleischmann is associate professor of pediatrics and director of renal services at Children's Hospital of Michigan, and Doctor McDonald is associate professor of medicine and director of nephrology.

* * *

C. Allen Payne, MD, Grand Rapids, is recipient of a Kent County Medical Society certificate of commendation for his many years of service to medicine. He is a past-president of KCMS, MSMS and the Michigan Medical Practice Board. He was also the 5th District Councilor to MSMS before becoming MSMS President.

* * *

George Morley, MD, Ann Arbor, is new president of the Society of Gynecologic Oncologists. Doctor Morley also is president of the Washtenaw County Medical Society.

* * *

Harry A. Towsley, MD, Ann Arbor, emeritus professor of pediatrics and postgraudate medicine at the U-M, is vice-chairman of the newly-formed Development Council of St. Joseph Mercy Hospital, Ann Arbor. The Development Council will assist the hospital in long-range fund-raising efforts to support hospital programs.

* * *

C. Mark Vasu, MD, Grand Rapids, president, Michigan Emergency Services Health Council, was a guest panel member for a conference on emergency medical services held recently at the White House. The meeting was one of a series of "Tuesday at the White House" sessions set up by President Ford to obtain information from experts on issues of national interest. President Ford made an unusual personal appearance at the meeting and noted that he had been made aware of EMS through the local Grand Rapids program several years ago. He credited his knowledge of EMS "all to my good friend, Doctor Mark Vasu. I have a lot of faith in EMS because I've seen it work," Ford assured the group. The President cited the Grand Rapids program as an example of "what can be done at the local level with some federal funding and local effort. What I saw illustrates that the people at the local level are far better able to decide how that money can best be spent and should be spent."

A soup-to-nuts agenda that includes proposed legislation on acute bed care methodology, radioactive wastes, public health statutes revision and definition of death is under study by the MSMS Committee on State Legislation and Regulations. Leading the committee is Thomas R. Berglund, MD, Kalamazoo, who detailed plans for further "malpractice legislation" in the February ***Michigan Medicine.***

In Memoriam

Burke W. Arehart, MD
Grosse Pointe Farms

Retired Detroit-area physician Burke W. Arehart, MD, died Feb. 27 at the age of 64. Doctor Arehart was a former board member of Saratoga General Hospital and was affiliated with Bon Secours, Holy Cross and St. John hospitals. He was a graduate of Wayne State University School of Medicine.

Kurt Baier, MD
Bloomfield Township

Kurt Baier, MD, staff member at St. Joseph's Mercy Hospital, Pontiac, since 1954, died Feb. 21 at the age of 50. Doctor Baier, an obstetrician-gynecologist, was graduated from University of Humboldt medical school in East Berlin. He was a member of the American College of Obstetrics and Gynecology and the Pan-American Medical Association.

Frank Check, MD
Detroit

Detroit obstetrician-gynecologist Frank Edward Check, MD, died Feb. 4 at the age of 61. Doctor Check was a graduate of St. Louis University medical school. He received the Air Medal during World War II.

Henry Holkeboer, MD
Grand Rapids

Henry David Holkeboer, MD, Grand Rapids family physician for 31 years, died Feb. 16 at the age of 77. Doctor Holkeboer had been a member of the Butterworth and Blodgett Memorial hospital staffs. He retired in 1960. He was a graduate of Northwestern University Medical School.

W. C. Huyser, MD
Kalamazoo

Kalamazoo surgeon and family physician for 61 years, William C. Huyser, MD, died Feb. 27 at the age of 89. Doctor Huyser was former president of the Kalamazoo Academy of Medicine and had been chief of staff at both Bronson and Borgess hospitals in Kalamazoo. He was a graduate of the University of Illinois medical school. He retired in 1974.

Saul Rosenzweig, MD
Detroit

Detroit cardiologist Saul Rosenzweig, MD, died Feb. 27 at the age of 75. Doctor Rosenzweig was a fellow of the American College of Physicians and the American College of Cardiology. He served on the staffs of Detroit General, Crittenton, Children's and Sinai hospitals. He had been chief of cardiology at the latter. Doctor Rosenzweig was a founding member of the Detroit Heart Club and was a member of the American Diabetes Association and American Heart Association.

Irwin H. Zielke, MD
Traverse City

Long-time Traverse City family physician Irwin H. Zielke, MD, died Feb. 20 at the age of 74. Doctor Zielke was on the staff of Munson Medical Center and was a fellow of the American Academy of Family Physicians. He was past president of the Grand Traverse-Leelanau-Benzie County Medical Society and was a graduate of Wayne State University School of Medicine.

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the Four-Week Period Ending February 27, 1976

	1976 This 4-Week Period	1975 Same 4-Week Period	1976 Total To Above Date	1975 Total Same Date	Total Cases for 1975
Rubella	161	148	249	252	1,975
Cong. Rubella Syndrome	0	0	0	0	1
Measles	260	291	311	443	3,253
Whooping Cough	13	7	20	23	98
Diphtheria	0	1	0	1	1
Mumps	789	1,041	1,386	2,306	9,979
Scarlet Fever & Strep Sore Throat	2,765	2,434	4,815	5,167	23,777
Tetanus	0	0	0	0	0
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	191	185	381	483	2,877
Salmonellosis (other than S. typhi)	78	54	125	143	864
Typhoid Fever (S. typhi)	0	1	0	1	10
Shigellosis	44	39	79	146	745
Aseptic Meningitis	3	7	17	14	280
Encephalitis	10	6	15	10	168
Meningococcic Meningitis	6	8	12	18	76
H. Influenza Meningitis	9	8	20	21	142
Tuberculosis	99*	83*	183*	233*	1,220
Syphilis	100	133	188	245	1,614
Gonorrhea	2,385	2,510	4,995	4,669	32,472

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

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* corrected totals

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NEED: Internist or Generalist at the Traverse City Office of the Disability Determination Program. Full time; good fringe benefits; competitive salary; ideal 4 season living area; and equal opportunity employer. No malpractice insurance required. Call: (517) 373-7789 (collect) OR Write: Michigan Dept. of Education, Vocational Rehabilitation Services, Disability Determination Program, Box 1200, Lansing, Michigan 48904, Att: David P. Gage, M.D., Chief Medical Consultant.

PHYSICIANS WANTED FOR BUSY CENTRAL TEXAS GENERAL PRACTICE: Opportunity for partnership and eventual ownership. Clinic adjacent to hospital. Good income. Close to Houston, Austin, San Antonio. Contact Willis G. Youens, Jr., M.D., or James E. Cummins, M.D., 105 N. Grohmann, Weimar, Texas 78962. (713) 725-8545.

PHYSICIAN IN FAMILY PRACTICE needed to join two other physicians in Essexville, Michigan. Lovely residential office in Bay City area. Excellent medical community. Fine schools. On Saginaw Bay with good recreational features. Excellent starting salary with partnership available. Write or call: Dr. A. Moeller, M.D., 700 Borton, Essexville, Michigan 48732 (517) 894-2926.

GP FP needed to associate with three GP MD's covering area of 150,000 people, three open hospitals with ICU, CCU and emergency room coverage. Liberal salary with incentive bonus. Pension and profit sharing plan. Rotate nights and weekends. Response to J. R. Young, M.D., 719 Capital Avenue, S.W., Battle Creek, Michigan 49015.

PROFESSIONAL SPACE AVAILABLE: Twenty Minutes Northwest of Ann Arbor in rapidly growing area. Four family practice suites and x-ray unit (with radiologist) already leased. There is also a medical laboratory in the building. Will custom design suite. Willing to defer part payment on first years' lease to later years'. If desired, may buy into building ownership. For more information, please call Dr. Marguerite Shearer at (313) 426-3469 after 7 p.m.

FOR SALE: Relax on this secluded, private 10 acre lake with 70¾ rolling, farmed acres. Go fishing, swimming and hunt on your own land. This is fine horse country. On a blacktop road in Lapeer County, 50 miles to Detroit. $10,000 down at $1,650 per acre. Owner moving south. (313) 773-5562.

DIRECTOR OF MEDICAL EDUCATION wanted for three hospital corporation in Bay City, Michigan. Must be a physician involved with education. Excellent salary. Fine medical community in lovely area. Write A. Moeller, M.D., 700 Borton, Essexville, Michigan or call (517) 894-2926.

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OB-GYN Certified or Board-Eligible, to join pro-life specialist in medium sized clinic. Call presently shared by three doctor arrangement. Fine N.E. Wisconsin City of 100,000. Excellent facilities. Starting salary & benefits over $50,000. Early partnership. Availability — immediate thru July 1977. Reply Box #3, 120 W. Saginaw St., East Lansing, Michigan 48823.

INTERNISTS, Certified or Board Eligible, for five doctor general internal medicine department in multi-specialty clinic. Sub-specialty practice possible. Fine N.E. Wisconsin City of 100,000. Excellent facilities. Starting salary and fringe benefits over $46,000. Early partnership. Availability — immediate thru July 1977. Reply Box #4, 120 W. Saginaw Street, East Lansing, Michigan 48823.

CALUMET-LAURIUM — Two or three family physicians needed to replace M.D.'s leaving practice to enter specialty. Newly remodeled hospital has over 80 acute beds, plus new emergency room, coronary care unit, and intensive care unit. Hospital staff includes family physicians, board surgeon, internist, part-time radiologist, part-time pathologist, and a fully trained orthopedic surgeon.

Opportunity exists to associate with practicing M.D.'s or to rent a fully equipped office. This is a chance to practice in a small community in a summer and winter recreation area, twelve miles north of Michigan Tech. University. The community has a growing school system and gradually expanding industrial base.

Calumet Public Hospital is a base for an excellent ambulance-paramedic unit servicing north Houghton and Keweenaw counties. The unit is extremely well equipped and has been fully trained by the trauma surgeon. The hospital also has departments of physical therapy and respiratory therapy, as well as some nuclear medicine diagnostic capability.

Send inquiries to Mr. Dion Paquette, Administrator, Calumet Public Hospital, Laurium, Michigan 49913; or to Kenneth E. Rowe, M.D., Director, Western U.P. District Health Department, 1100 Quincy Street, Hancock, Michigan 49930.

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CHILDREN'S SERVICE: DETROIT PSYCHIATRIC INSTITUTE: Positions available for Child Psychiatrists (full time or part time) as chief of service or staff psychiatrists.

The Children's Service consists of an out-patient unit and a 12 bed in-patient unit. D.P.I. is an agency of the Department of Mental Health, State of Michigan, and part of Wayne State University, Department of Psychiatry. It is an active treatment and training center in the heart of the Detroit area.

Psychoanalytically oriented child psychiatrists (Board Certified or eligible) are urged to apply. Positions available July 1, 1976. Salary depends upon training and experience.

Contact: Bernard Chodorkoff, Ph.D., M.D., Detroit Psychiatric Institute, 1151 Taylor, Detroit, Michigan 48202 (313) 876-4430 or (313) 876-4431.

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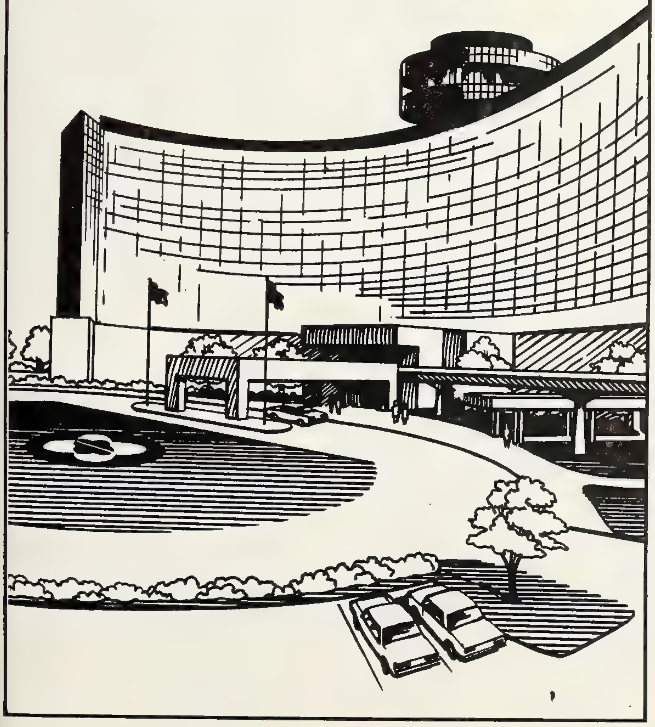

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POTPOURRI

How important is it that physicians participate in continuing medical education as a way to improve their skills? Because a physician in a California clinic missed in diagnosing breast cancer in a patient, the patient was successful in being awarded $1 million in damages in a Los Angeles court.

* * *

The Newhouse newspaper chain predicts that by 1980, Flint will have the third highest income per household in the nation. The Flint figure will be $27,635 for a growth of 58.9% between 1974-1980. Saginaw is predicted to be the sixth highest in the nation, up 57.1% to $26,348 income per household. Also among the top 20 cities in the nation will be Ann Arbor (12th), up 41.4% to $25,328; Detroit (16th) up 42.1% to $24,499; and Lansing/East Lansing (19th) up 48.3% to $24,376.

* * *

"Medicine must expose government when it regulates for the masses rather than serving the concerns of individuals," so declares Chicago attorney, Newton Minow.

* * *

Accuracy is something about which all ediotrs are concerned.

* * *

At the 1976 AMA Congress on Medical Education, Economist Milton Friedman, Chicago, advocated the end of all licensing. To illustrate his point, Friedman said, "licensing can be ridiculous — licensing laws even require that professional wrestlers must be of high ethical persuasion."

* * *

One of the component society leaders reports attendance is good because the meeting notice often lists "Possible Dues Increase" as an agenda item.

Ano Ny Mouse, MD, writes in the newsletter of the Michigan Chapter of the American Academy of Pediatrics, that "Every Reform Starts as a Private Opinion."

* * *

Journalist Bill Moyers hits the following theme hard in his columns and platform appearances: "There is no self without the other. There is not 'me' without 'you.' There is no 'we the people' without 'each other'."

* * *

Need more be said? Out of 100 letters received by legislators only four say "thank you." That information was shared by Gene Dyson, nationally-known teacher re politics, at the last MDPAC workshop.

* * *

The AMA House of Delegates has approved recommendations of the Long Range Planning and Development Committee "to appoint committees with limited time-frames to accomplish specific goals." That has been a practice at MSMS in recent years with task forces for specific assignments.

* * *

An article in Harvard Business Review recently reported that thinking people are more likely to act on a tip from a friend than on a written research report.

* * *

Old notions about the division of labor between women as child bearers and men as breadwinners may be gone forever. Today, 39% of adult women do not have husbands.

In 1975, the AMA provided a $1,500 per year tax savings for those in the 40% tax bracket as a result of improvements in the Keogh law permitting increased annual contributions for retirement to 15% of earned income, or $7,500.

* * *

There is a movement in newspapers to publish more everyday, useful information to help readers. Promoters of that idea want the people to refer to newspapers as "usepapers." That is exactly in keeping with what the MSMS Publications Committee and MSMS Council have in mind with the new format and new content of this *Michigan Medicine* news magazine for physicians.

* * *

Did you know that Cobo Hall couldn't hold all the physicians the AMA helped put through medical school? Every year, thousands of young medical students from Michigan and other states turn to the AMA-ERF to help arrange for loans. In the past 11 years, the AMA has arranged for over $57 million in loans to more than 26,000 medical students, interns and residents.

* * *

"If the malpractice morass is to be untangled," says Indiana Governor Otis R. Bowen, MD, "we need more intelligent thinking and less finger-pointing." He added, "Indiana would not have its new professional liability laws if we had allowed a doctor-versus-lawyer-versus-insurance company cat fight."

* * *

In our nation, more is spent on antacid commercials that mislead people about the shape of the stomach than is spent on educating people about economics.

* * *

Suggested bicentennial slogan for MSMS members this month: "Take pride in MSMS's past, take part in MSMS's future."

The new MSMS president rates further resolution of the malpractice situation as first among the coming year's challenges.

Doctor Leitch's inaugural president's page appears on page 236 inside.

MICHIGAN MEDICINE

FFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 5 MAY 1976

One community hospital's CME program and how it works: the system at Grand Rapids' Blodgett Hospital is described by Director of Medical Education Robert L. Tupper, MD, beginning on page 244.

Appropriations to the Department of Social Services, including Medicaid reimbursements, overshadow all other current legislation, according to MSMS Government Relations Manager Bruce Ambrose. He reports on them and other key legislative items on page 285.

The recent MSMS survey of availability of physicians' care shows larger percentages of Michigan physicians accept new patients, but smaller percentages accept Medicaid patients. See page 240.

MICHIGAN
Pioneer in Progress

MAY 15-22
MICHIGAN WEE

Will Michigan's framework for providing its citizens with the best possible health care stand the stress tests of current economic shortages? Study the analysis and urgings of the governor, state department heads, educators, physicians, health planners and association heads inside, for a look at the problem from several angles. See Pages 253-266 inside.

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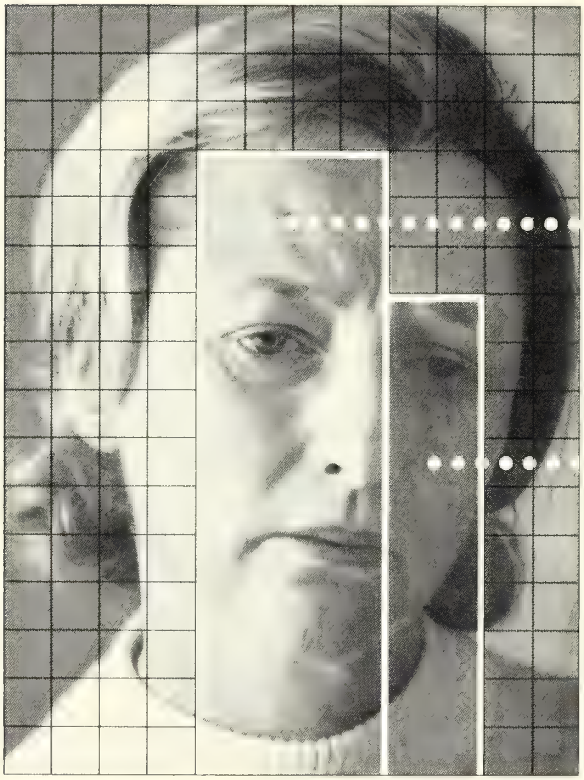
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue

All parties involved finally have agreed upon the long-awaited standardized claims form to be used by Michigan physicians to obtain reimbursement from insurance companies. The forms (actually four) and articles to explain their use will be printed in the June issue of **Michigan Medicine.**

In addition, the journal will provide full information on the rates and claims of the Michigan Physicians Mutual Liability Company. Don't miss these vitally important articles.

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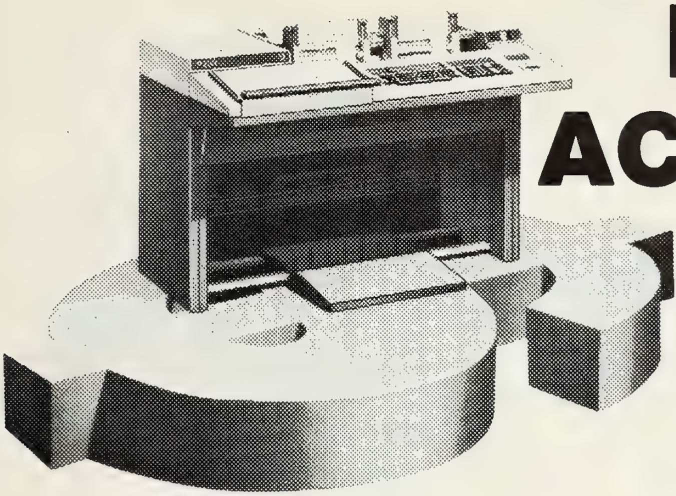

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The Challenges of the Coming Year

Robert M. Leitch, MD
MSMS President

With this column, Doctor Leitch begins his year-long association with *Michigan Medicine*. He was installed May 1 as president of MSMS. Doctor Leitch is a family physician in Battle Creek and a graduate of the University of Michigan. He has served as delegate to MSMS and as Council Chairman for three years.

As I look into the year ahead, a number of challenges confronting the membership of the Michigan State Medical Society seem apparent.

Of prime importance is further resolution of the malpractice situation. We need to get our Michigan Physicians Mutual Liability Company well on its way. We need to push for additional legislation to further improve the situation.

Currently the medical society is supporting bills to legally define malpractice, further strengthen the statute of limitations, change judgment awards from lump sum to annuity-type payments, and obtain affidavit of merit, burden of proof and waiver of privilege legislation. These bills would have permanent effect and their impact would be as great as the package of bills already passed during the 1975 legislative session.

In addition, we need to develop more programs to aid doctors in obtaining their required CME credits, make sure these programs are available locally and get more community hospital programs approved for Category I credit.

Thirdly, we need to pay careful attention to state and national legislation, such as the public health statute revision bills and national health insurance proposals, which will have impact on medical care.

As I lend my leadership to the state medical society's efforts in these directions, I hope to see the malpractice situation improved, MPMLC activated and all physicians in the state adequately covered by insurance. I hope to see several more good CME programs in place that will assure doctors of gaining needed credits easily and economically, and I hope to see our good influence evident in the outcome of key legislation.

We will have a highly successful year if we implement these programs.

I consider it a high honor to serve as your president during 1976-77. I hope to provide the quality of leadership provided by former presidents. I plan to be as available as possible to MSMS members, component societies and other groups who ask for our assistance.

I welcome the suggestions, comments, advice and assistance of all my colleagues as we move ahead with this new year in our society's life.

I urge each MSMS member to become concerned with the political programs and the moral and ethical issues facing us, as well as with the practice of medicine. Let's move forward together.

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3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

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Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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A waiver of premium provision has been added and a new rate structure has been designed which results in lower premiums for most age groups. The certificate of insurance has been rewritten in more readable language.

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For further information, contact the administrators, Stratton-Cheeseman & Associates, Inc., P.O. Box 1563, East Lansing 48823. Or call collect 517/351-5780. The underwriting company is Provident Life & Accident Insurance Company.

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Director

MSMS survey: Michigan MDs taking fewer new Medicaid patients

(From the MSMS Bureau of Economic Information)

Over 2,100 MSMS members completed and returned the recent MSMS Bureau of Economic Information's Survey on the Availability of Medical Care. Many interesting and significant findings were shown through tabulation of the data.

The survey was designed exactly like one that was sent to a sample group of primary care physicians in April, 1973. This was done so that meaningful comparisons of the data could be drawn.

This year's survey was tabulated to reflect the responses of primary care physicians (general and family practice, internal medicine, pediatrics, obstetrics-gynecology, and general surgery), all other specialties as a group, and the total response. In addition, the state was divided into five geo-economic areas. The counties included in each area were: Area 1 — Wayne; Area 2 — Oakland, Macomb and Washtenaw; Area 3 — Bay, Calhoun, Ingham, Jackson, Kalamazoo, Kent, Midland, Muskegon, and Saginaw; Area 4 — All other lower peninsula counties, and Area 5 — all upper peninsula counties.

The findings show a significant change in physicians' attitudes regarding Medicaid patients from three years ago. Highlights of the results are as follows:

1. Of the 2,147 surveys received, 2,004 (93.3%) are from physicians who provide office-based patient care.

2. Of those who provide patient care, 1,919 (95.8%), accept new patients. In 1973, only 92.7% of those surveyed accepted new patients.

3. Of the 2,004 physicians that provide patient care, 1,812 (90.6%) indicate that they give medical care to Medicaid patients. Three years ago, 94.7% stated that they care for Medicaid patients.

4. Out of the 1,919 MDs who accept new patients, 1,311 physicians (68.3%) responded that they would accept new Medicaid patients. This is a substantial drop from the 83.5% that accepted new Medicaid patients in 1973. **Table 4** shows that 65.4% of the 2,004 physicians who provide office-based patient care accept new Medicaid patients.

5. The concerns that physicians mentioned most often with regards to the Medicaid program fit into the following categories (in order of frequency mentioned): a) the amount MDs are paid for their services and the recent 11% drop in fees b) patient abuse and overutilization of the services available; c) the extensiveness of the claim form and the bureaucracy with which physicians must deal; d) arbitrary rejection of claims and delay of payment; e) general complaints regarding the program (cost, computers, administration); f) government intervention in medical care; and g) other.

Many physicians also indicated on their surveys that they are trying to phase out their Medicaid patients so as not to have to deal with the program at all.

Specialty Group A = all primary care physicians

Specialty Group B = all other specialties

TABLE 1

QUESTION: Do you accept any new patients?

	AREA 1			AREA 2			AREA 3		
	Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total
YES	94.9%	98.4%	95.9%	95.5%	99.1%	97.1%	92.9%	99.6%	95.2%
NO	5.1%	1.6%	4.1%	4.5%	0.9%	2.9%	7.1%	0.4%	4.8%

	AREA 4			AREA 5			
	Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total	STATE TOTAL
YES	94.1%	100.0%	95.0%	94.4%	100.0%	95.7%	95.8%
NO	5.9%	0.0%	5.0%	5.6%	0.0%	4.3%	4.2%

TABLE 2

QUESTION: Do you care for Medicaid patients?

	AREA 1			AREA 2			AREA 3		
	Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total
YES	80.1%	82.9%	81.1%	92.2%	87.7%	90.2%	94.6%	91.8%	93.6%
NO	19.9%	17.1%	18.9%	7.8%	12.3%	9.8%	5.4%	8.2%	6.4%

	AREA 4			AREA 5			
	Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total	STATE TOTAL
YES	95.0%	93.0%	94.7%	98.3%	100.0%	98.6%	90.6%
NO	5.0%	7.0%	5.3%	1.7%	0.0%	1.4%	9.4%

TABLE 3

QUESTION: What percent of your patients are on Medicaid?

AREA 1			AREA 2			AREA 3		
Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total
14%	12%	13%	10%	7%	9%	13%	12%	13%

AREA 4			AREA 5			
Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total	STATE TOTAL
16%	12%	15%	17%	15%	16%	12%

TABLE 4

QUESTION: Do you accept *new* Medicaid patients?

	AREA 1			AREA 2			AREA 3		
	Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total
YES	51.2%	67.5%	56.0%	55.7%	74.6%	64.4%	61.5%	83.5%	69.1%
NO	48.8%	32.5%	44.0%	44.3%	25.4%	35.6%	38.5%	16.5%	30.9%

	AREA 4			AREA 5			
	Specialty Group A	Specialty Group B	Total	Specialty Group A	Specialty Group B	Total	STATE TOTAL
YES	64.0%	87.7%	67.8%	75.4%	87.5%	78.1%	65.4%
NO	36.0%	12.3%	32.2%	24.6%	12.5%	21.9%	34.6%

Estate planning

When a physician draws up a will, s/he should follow a checklist as below to ensure that s/he plans well. The physician may tear out and retain this page as a handy guide in planning for an estate.

1. Full legal name, address, birthday of you, your spouse, children, grandchildren.
2. List any special physical or emotional problems with anyone in your immediate family.
3. List all of your assets. Make four columns to indicate ownership: Husband, Wife, Joint, Other. Assets should include stocks, bonds, life insurance, real estate, copyrights, patents, stamp and coin collections, royalties, paintings and sculptures, furniture, jewelry, contract rights, money owed to you, stock in your professional corporation, pension and profit-sharing plans, HR 10, (Keogh), Tax Sheltered Annuities at the hospital. List date purchased, whose money used (husband or wife) and present value of each asset.
4. List all of your liabilities, including mortgages and loans; list names and addresses of creditors and for what purpose money was borrowed.
5. If you own any property with someone else (other than your wife), do you have a written agreement covering death or voluntary sale?
6. List place of safe deposit box, where keys are kept and who has right of entry.
7. Did you have any previous marriages or children?
8. List your objectives in general terms as to what income you would want your family to have upon your death.
9. Are you or your wife or children the beneficiary under any trust funds?
10. Are you supporting any persons other than your wife and children, such as parents or grandparents?
11. Whom do you wish to serve as guardians of your minor children upon the death of you and your wife? The guardians will have to serve as "parents" to your minor children.
12. If a trust is in order for your family, whom do you wish to name as Trustee? The trustee will have to manage the assets, make the proper investments and pay the money out to the beneficiaries.
13. If a trust is in order, at what age or ages do you wish the beneficiaries to receive any of the trust, outright?
14. Do you wish to treat one child more or less favorably than the others?
15. To whom do you wish to leave your assets if nobody in your family survives you (in case of a common disaster, for example)?

Source: *The APPA Digest,* June, 1973.

MSMS-AMA Workshop June 2-3 to help you establish practice

If you're a new physician just starting practice or an established doctor wanting to improve your efficiency, the MSMS and AMA invite you to attend a two-day workshop June 2-3 at the Michigan Inn, Southfield.

Entitled "Establishing Yourself in Medical Practice," the workshop is cosponsored by the Michigan Association for Medical Education.

The program on the first day begins with registration at 8 a.m., followed by morning presentations on personnel problems, including recruiting and interviewing, training and evaluation, dealing with conflicts, setting policies and procedures, task analysis and delegation of authority.

Afternoon sessions will be devoted to patient flow techniques and physical aspects of the medical office.

The second day's program will include morning sessions on clinical and financial paperwork, a noon session on the socioeconomic aspects of medical practice, and afternoon meetings on the practice setting and legal problems.

Leaders of the workshop will be professional management consultants from California, and A. Stewart Kerr, MSMS legal counsel.

**One contains aspirin.
One doesn't.**

Darvocet-N® 100
100 mg. propoxyphene napsylate
and 650 mg. acetaminophen

**Darvon®
Compound-65**
65 mg. propoxyphene hydrochloride,
227 mg. aspirin, 162 mg. phenacetin,
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Additional information available to the profession on request.
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500341

Your hospital might take ideas from Blodgett Hospital's CME

By Robert L. Tupper, MD
Blodgett Director of Medical Education

Blodgett Memorial Medical Center has long operated an informal continuing education program for its medical staff. In recent years, there has been growing pressure for continuing education from specialty boards. And now, with the recent enactment of the Michigan law requiring continuing medical education for physician relicensing, the decision was made by the Blodgett staff executive committee to formalize this program.

Specifically, we now have a Continuing Medical Education Committee of the Medical Staff, which is responsible for the organization and operation of an accredited program of continuing medical education. This committee is chaired by Arthur K. Hamp, MD, with Robert L. Tupper, MD, the Vice Chairman, and with representatives from the departments of medicine, surgery, OB/GYN, pediatrics, special surgery, radiology and pathology, who function as continuing education coordinators for their departments.

Early on, it was quickly realized that most of Blodgett's staff members in fact, acquire the required Category I-V hours at national meetings, but several physicians might need the assistance of some accredited meetings at Blodgett.

It was decided to attempt to provide accreditation for the weekly departmental meetings in medicine, surgery, OB/GYN, pediatrics, as well as to include the various city-wide visiting speaker programs and special events.

The committee's original intent had been to accredit a great many more of the activities ongoing at the Medical Center, but when it faced the realization of how much work was involved in carrying out the requirements of the accreditation process for each one of those activities, it was decided to cut back to the above activities.

Anatomy

The basic requirements for a continuing education program to be accredited include the following components:

First, there must be a central focus. There must be an identified office, address, phone number, and staffing, along with the capability of making arrangements for whatever might be necessary for meetings, including record-keeping capability.

Second, there must be a broad-based planning committee which has the responsibility for overseeing the program and for planning a curriculum on at least an annual basis.

Third, there must be a method of determining need for continuing medical education. The era in which continuing education consisted solely of a variety of visiting speakers talking about their favorite exotic topics, has passed. Today, an accredited program must be able to prove that a significant portion of its content is directly related to identified patient care problems in that institution.

Fourth, there must be a two-part evaluation system which evaluates individual programs relative to their quality and their identified educational objectives and which, as well, will help identify whether the overall program is improving patient care.

Fifth, there must be a method of compiling records of meeting content or curriculum and for maintaining individual physician attendance records for credit hour reporting to the Medical Practice Board on its request.

These then are the crucial bricks that a continuing medical education committee, including Blodgett's, must use in building the program each year.

Physiology

As our system is arranged, the five main components depend upon each other. Thus, as the audit committee at Blodgett studies various diagnoses and encounters areas in which it thinks continuing education might improve staff performance, the audit committee should communicate this information to the continuing education committee, with the request that the subject be built into program planning.

In the same way, the findings of the Blodgett infection control committee, the pharmacy and therapeutics committee, the utilization committee and perhaps other committees should be, whenever appropriate, communicated to the continuing education committee. In addition, the members of the committee should consult with their respective departments and attempt to identify those new developments that are appearing in the various fields of medicine, and how they should be brought to the attention of the staff.

The departmental representatives on the continuing education committee, (or continuing medical education coordinators) have the responsibility of meeting with the chairman of the department, as well as with the departmental graduate education coordinators and working appropriate topics into the ongoing schedule of educational meetings.

The continuing medical education coordinators have the additional responsibility of meeting with various speakers to be sure that they are able to express the educational objectives for the program. This is a recent concept, which is also a component of an approved program. Educational objectives should be presented at each meeting and in essence indicate what the purpose of presenting that subject is, or what the physician in the audience is expected to take away from that meeting.

(Continued on page 248)

category 1 programs

Michigan Medicine ***each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.***

Date: May 12-13 — Quality Assurance Tutorial
Location: Ann Arbor (See April 7-8)
Sponsor: Commission on Professional and Hospital Activities
For: PAS member hospital teams
Cost: Hospital team of five, $155
Contact: CPHA, 1968 Green Road, Ann Arbor, MI 48105
Approved for: 13 Hours of Category I Credit

* * *

Date: May 13-14, 1976 — Advances in Cardiac Pacing
Location: U-M, Towsley Center Ann Arbor, 48109
Sponsor: Department of PGM/HPE
Cosponsor: American heart Association, Council of Clinical Cardiology
For: Cardiologists, Thoracic Surgeons
Cost: Practicing Physicians — $120/65
Phvsicians-in Training — 60/35
Contact: U-M Department of CME*
Approved for: 14¾ hours of Category I Credit

* * *

Date: May 18-21, 1976 — Advances in Internal Medicine
Location: Towsley Center for Continuing Education
Sponsor: U of M Medical School PGM/HPE
For: Internal Medicine
Cost: $220 or $55/day for practicing physicians
$110 or $30/day for physicians in training,
plus $12.00 dinner fee
Contact: U-M Office of Intramural Education*
Approved for: 31 Hours of Category I Credit

* * *

Date: May 21
Location: WSU Scott Hall
Sponsor: Wayne State University Department of Pathology
For: Pathologists, medical examiners, law enforcement, hospital and lab technicians
Cost: $25
Contact: Waldemar A. Palutki, MD, 540 E. Canfield, Detroit, 48201
Approved For: 6½ applied for hours of Category I Credit

* * *

Date: May 22, 1976 — Pediatric Forensic Pathology Conference
Location: E. W. Sparrow Hospital, 1215 E. Michigan, Lansing
Sponsor: E. W. Sparrow Hospital
For: Pediatricians and pathologists
Cost: None
Contact: Gladys M. Tomas, PhD, Department of Pathology, E. W. Sparrow Hospital, Box 480, Lansing 48902
Approved for: 4 Hours of Category I Credit

* * *

Date: June 7-11, 1976 — Principles and Practice of Industrial Toxicology
Location: Hyatt Regency, Dearborn
Sponsor: Wayne State University Department of Occupational and Environmental Health
For: Industrial physicians, public health officials, hygienists
Cost: $350.00
Contact: WSU Continuing Education**
Approved for: 14 Hours of Category I Credit

* * *

Date: June 21-25
Location: Shanty Creek Lodge, Bellaire
Sponsor: U-M Medical School, Dept. of PGM/HPE
For: Family physicians
Cost:
Contact: U-M Office of Intramural Education*
Approved for: 6½ applied for hours of Category I Credit

* * *

Date: June 30-Sept. 8 — Instrumentation in Clinical Biochemistry (2 hours weekly)
Location: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
Sponsor: WSU Department of Pathology
For: Hospital pathologists
Cost: $154.00
Contact: WSU Continuing Medical Education**
Approved for: Hour for Hour Category I Credit

* * *

Date: October 28-30 — The Human Vagina: biological and clinical aspects.
Location: WSU
Sponsor: WSU Department of Obstetrics-Gynecology
For: Gynecologists — General Medicine
Cost:
Contact: WSU — Dept. of OB-GYN, 540 E. Canfield, Detroit 48201
Approved for: 45 pending hours of Category Credit

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* Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**Continuing Medical Education, 1206 Scott Hall, 540 E. Canfield, Wayne State University, Detroit 48201.

Here is a list of all Michigan institutions that have been approved to offer Category I continuing education credit.

Alma-Gratiot Community Hospitals
William Beaumont Hospital
Blodgett Hospital
Bon Secours Hospital
Burns Clinic Medical Center, PC
Henry Ford Hospital
The Grace Hospital
Ingham Medical Center
Pontiac General Hospital
Saginaw Cooperative Hospitals, Inc.
Edward W. Sparrow Hospital
St. John Hospital
St. Joseph Mercy Hospital
St. Lawrence Hospital
Ypsilanti State Hospital
Wayne County Psychiatric Hospital
MSMS Committee on CME Programming

Testing in Humans: Who, Where & When.

he weight of ethical opinion:

Few would disagree that the effective- ess and safety of any therapeutic agent r device must be determined through inical research.

But now the *practice* of clinical re- arch is under appraisal by Congress, the ress and the general public. Who shall dminister it? On whom are the products be tested? Under what circumstances? nd how shall results be evaluated and tilized?

The Pharmaceutical Manufacturers ssociation represents firms that are sig- ificantly engaged in the discovery and evelopment of new medicines, medical evices and diagnostic products. Clinical esearch is essential to their efforts. Con- equently, PMA formulated positions hich it submitted on July 11, 1975, to e Subcommittee on Health of the Sen- te Labor and Public Welfare Committee, s its official policy recommendations. ere are the essentials of PMA's current inking in this vital area.

1. PMA supports the mandate and ission of the National Commission for e Protection of Human Subjects of iomedical and Behavioral Research and ffers to establish a special committee omposed of experts of appropriate isciplines familiar with the industry's esearch methodology to volunteer its ervice to the Commission.

2. PMA supports the formation of an dependent, expert, broadly based and epresentative panel to assess the current ate of drug innovation and the impact pon it of existing laws, regulations and rocedures.

3. When FDA proposes regulations, should prepare and publish in the *Fed- al Register* a detailed statement assess- g the impact of those regulations on rug and device innovation.

4. PMA proposes that an appropri- ely qualified medical organization be ncouraged to undertake a comprehen- ve study of the optimum roles and esponsibilities of the sponsor and physi- ian when company-sponsored clinical esearch is performed by independent inical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A

Pharmaceutical Manufacturers
Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

The departmental continuing medical education coordinators also have the responsibility of seeing that the medical education secretaries are present at each one of the meetings to distribute evaluation forms to those in attendance. These forms will be passed out the first 10 minutes of each meeting only. People arriving later than that will not be able to obtain such a form, which not only provides evaluation, but also a record of attendance. In addition, the coordinators will be responsible for the collection of the evaluation forms at the conclusion of the program. Forms turned in prior to the conclusion or those turned in hours or days after the conference, will not be accepted. These time constraints reflect a carefully considered decision made by the continuing medical education committee with the support of the staff executive committee.

Each continuing medical education coordinator then has the responsibility of reviewing the evaluation forms turned in for each meeting and preparing a summarizing commentary from those forms. These summaries will be presented to the continuing education committee as a whole, reflecting on the performance of the individual speaker and his program, what the educational objectives were, what the source of need for that subject was, as well as a brief notation on the content of the program. The secretarial staff will carry out the responsibilty of registering each individual physician's attendance, so that the continuing education office will, at the end of the year, be able to verify the number of hours of Category I credit for each physician.

The continuing education committee will have the responsibility of reviewing the overall program to make sure that a full range of subjects within each discipline is covered during the period of a year or more, as a means of defining an inclusive curriculum.

Finally, as a means of completing evaluation, the continuing education committee may at any particular point, ask the audit committee or another committee, to reassess a particular problem, to determine whether the Continuing Medical Education Program made a difference.

Conclusion

The above system realizes the goal of our continuing medical education committee: it represents a very simple, organized program of continuing medical education which is aimed not only at satisfying the needs of the members of the medical staff for continuing education credit for licensure purposes, but also at satisfying: (1) Medical staff requirements for accreditation by the Joint Commission; (2) Requirements of the state hospital licensing law; (3) Requirements of the hospital professional liability carrier, and (4) The education component of our American College of Surgeons-approved cancer programs.

This type of continuing education program targets directly on efforts to improve the quality of patient care. Further, it provides a specific channel for the use of the results coming from the various staff committees. Hopefully this program will be efficient, effective and beneficial to all concerned.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

When pain complicates acute cystitis*

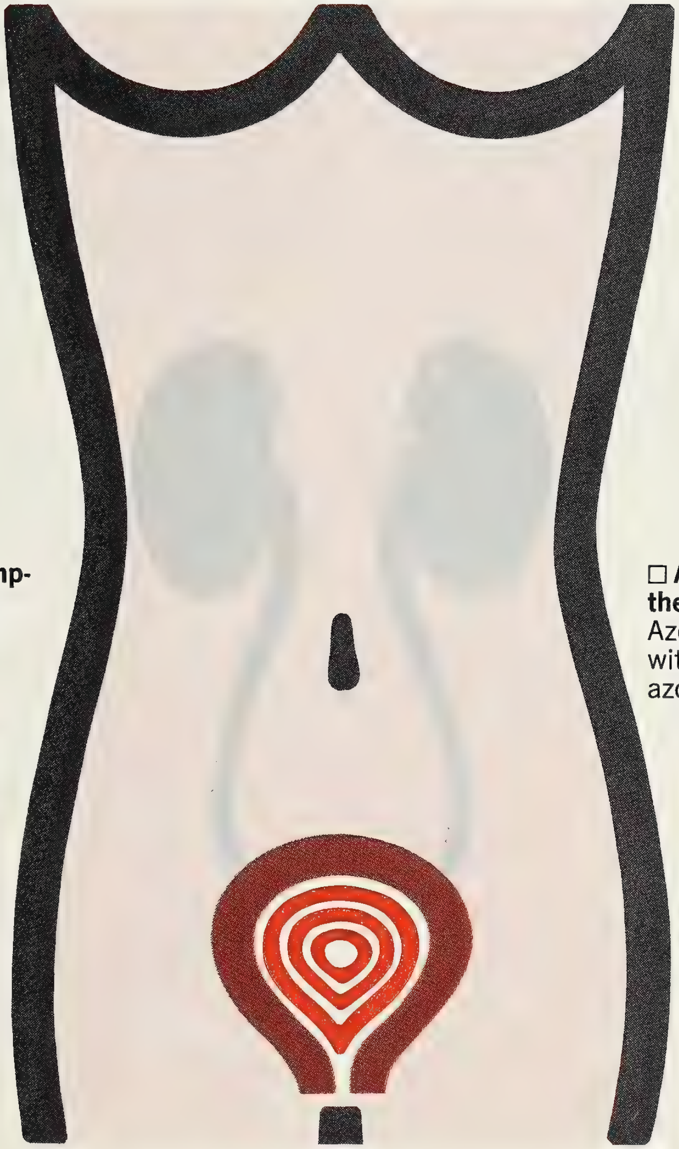
Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain for the pathogens

☐ **Early relief of painful symptoms** such as burning and discomfort associated with urgency and frequency.

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*



☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

ROCHE

DYAZIDE® MAKES SENSE

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)

SPARES POTASSIUM

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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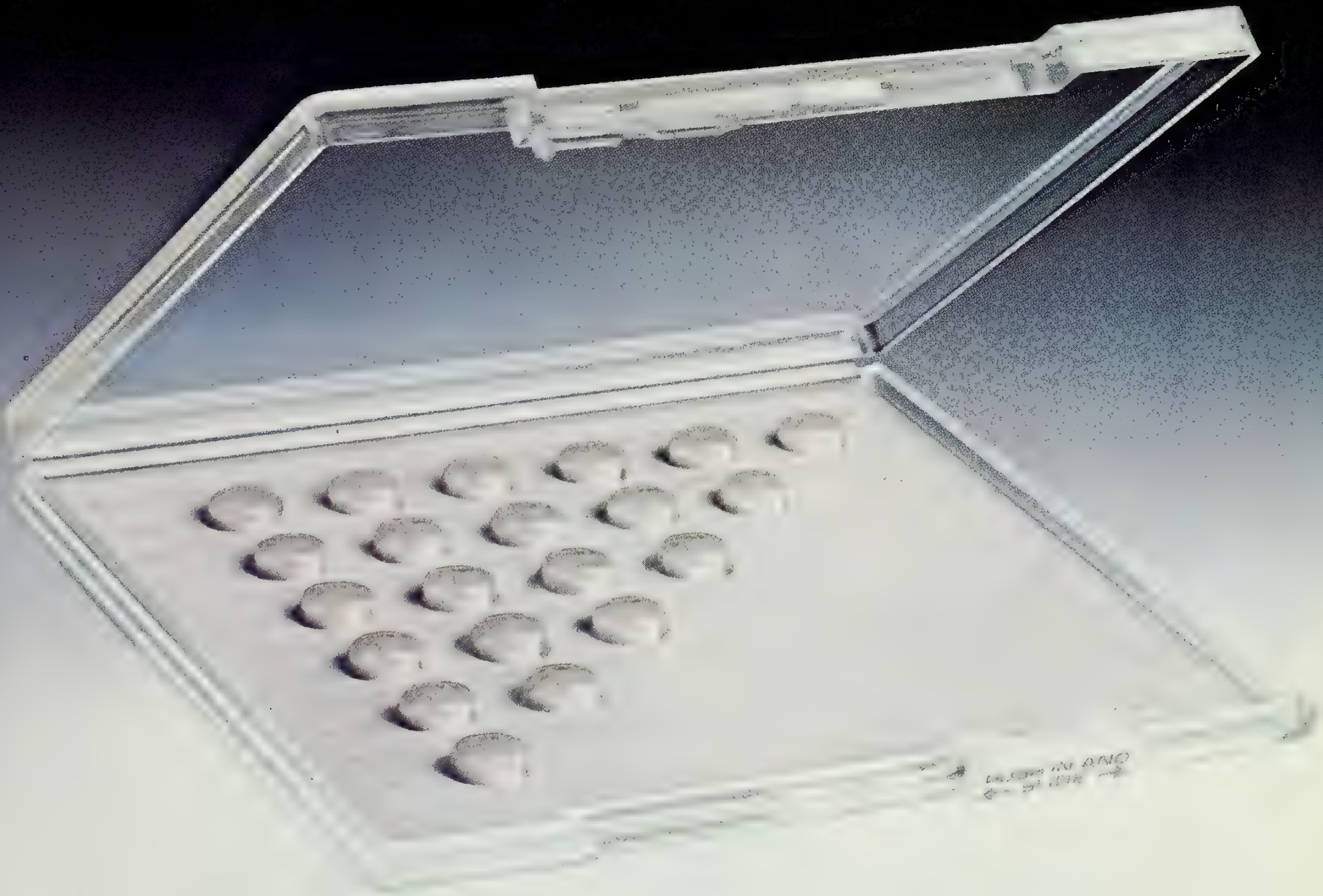

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Natural balance
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□ Found useful in the management of vertigo* associated with diseases affecting the vestibular system.

□ Can relieve nausea and vomiting often associated with vertigo.*

□ Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

□ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.

□ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of th teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestatio has produced cleft palate in the offspring. Limited studies using doses of over 100 mg kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palat Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hyper sensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patien should be warned of this possibility and cautioned against driving a car or operatin dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in childre have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurre vision have been reported.

More detailed professional information available on request.

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Antivert®/25

(meclizine HCl) 25 mg. Tablets

for vertigo*

In celebration of Michigan Week

Michigan's medical picture in Spring, 1976, as it looks to:

William G. Milliken, Governor, The State of Michigan

In the state of the state message this year, I called for a renewed alliance for health in Michigan.

Changes in our mental health laws, expected development of a unified public health code, and the establishment of a new structure for comprehensive health planning dictate that the partnership of government and health care providers and consumers be strengthened.

We must not fear these new challenges, but neither must we bury our heads in the sand, waiting for events to control our actions.

Apart from the statutory and organization changes indicated above, other factors require the strengthening of public and private sector ties in the health care area.

Few would argue that we are more than several years away from some form of national health insurance. Such a program will place additional strains on relations between government regulators and private providers.

Federal funding for health programs, particularly Medicaid and Medicare, has increased exponentially since 1965, and increasingly, the services which these monies purchase have come under closer federal and state scrutiny. Accountability and evaluation of services become increasingly important to the state as the state's share of Medicaid expenditures increases. The state's financing of Medicaid, for example, will approach $400,000,000 by the next fiscal year and spending on behalf of other public and mental health programs will be in excess of $400 million in 1976-77.

Despite these expected expenditures, the state is unable to provide all the financial support that ideally we should. Because of the severe economic recession, and the concomitant shrinking revenue base and increasing demands, some of our health programs will be funded below inflationary rates.

That dilemma requires that all of us make a special effort to set priorities as rationally as we can. It also means that now, more than ever, we need to be innovative.

We need you

We, in government, need your counsel. The medical community can, and must, be given every opportunity to help guide us to the most responsible and effective spending of our limited health care dollars.

MICHIGAN
pioneer in progress

MAY 15-22
MICHIGAN WEEK

To a great extent, the partnership of government and the private sector led to the balanced — and, over the long run, what I consider to be effective — groundwork for a solution to the medical malpractice insurance crisis in Michigan.

My concern, as well as yours, is that some will say that the crisis has been solved, never to recur. While I wish that were the case, I believe that only through careful monitoring and appropriate legislative and administrative responses can we be assured that a future crisis will be avoided.

It would be inappropriate for me to leave this issue, an excellent example of the mutual benefits derived from a strong alliance, without commending the Michigan State Medical Society for its great assistance to us in drafting and achieving enactment of the legislation last year.

I see a wide range of issues, with which the alliance for health should be vitally concerned in the coming months.

Legislatively, the package of bills, SB 984-985-986-987, designed to improve our ability to render emergency medical services, has the potential of saving many lives each year through faster response to critical life-threatening situations. I ask your support for these bills.

Of course, the focus of most of our legislative interest will be the recommended codification of our public health laws, which will be presented to me and the Legislature by the Public Health Statute Revision Project. I seek your guidance on the numerous recommendations of the project, and I hope that after thorough legislative review, we can set a high priority on the codification's passage.

I have asked the departments of public health and mental health to emphasize health preventive efforts in a number of areas. The substance abuse prevention/education project, chaired by Lieutenant Governor Damman, the implementation of our program to develop and regulate health maintenance organizations, with support from the Insurance Bureau, improvements in our capability to provide basic immunization to every Michigan child, continued development of environmental epidemiology to guard against dangerous exposures to dangerous chemicals, and development of programs and services geared to prevention of mental illness and mental retardation are among the priority efforts being undertaken.

I fully endorse these efforts, and ask that health professionals outside of state government help us to develop the best programs possible in the preventive health area.

Government cannot do it alone

The message, again, which I want to convey is that we in state government cannot do it alone. Our responsiveness to citizen needs hinges, in large measure, on the extent to which physicians make us aware of those needs and offer their recommendations for meeting them.

The structure for a rejuvenated alliance for health in Michigan is now being developed. Under Public Law 93-641, we are designing a comprehensive and restructured health planning process. I have placed expanded planning and program development tasks in the Office of Health and Medical Affairs, in the Department of Management and Budget.

Governor Milliken

> ***"Our responsiveness to citizen needs hinges . . . on the extent to which physicians make us aware of those needs and offer their recommendations for meeting them."***

MICHIGAN
pioneer in progress

Most importantly, I have recommended creating a Statewide Health Coordinating Council in the Office of the Governor. It is evident that the federal government will place considerable authority in the hands of this council, in terms of health planning and establishment of priorities. It will be a broadly-based group of individuals: consumers and providers from every area of the state.

I visualize this council as the keystone of the alliance for health in Michigan. Your participation on the council, your recommendations to the council, and your commitment to the objectives of the council will be critical to its success.

I hardly have to emphasize the critical period in which we find ourselves. Economic stress tests our capacity to fight the danger of a double standard of care — one for the rich, and one for the poor.

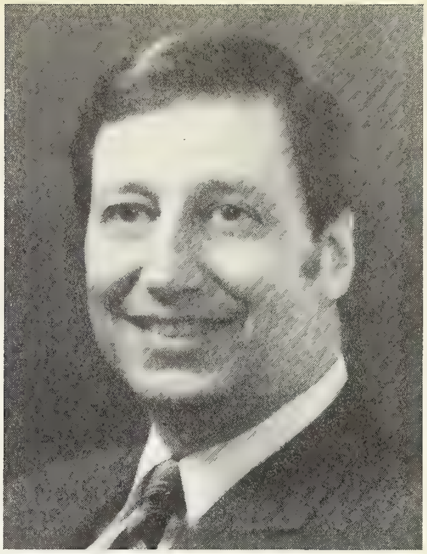
The increasing influence of government in the payment of and regulation of health services threatens, from time to time, to place us in state government, and you in your roles of direct providers, in adversarial positions. The increasing size of our government and scale of health services and consumer demands often forces us to lose sight of individual problems and needs.

Let us set aside the pronouns, "me and you," and let those of us who share the common objective of the best health care for the most people work in an alliance for that goal. Let us establish the closest working relationship in determining needs. And let us, together, build upon the fine health care system we have to obtain the best health care system that we humanly can.

THANK YOU

as it looks to:

Maurice S. Reizen, MD, Director Michigan Department of Public Health



Doctor Reizen

> ***"Beyond medical care is the maintenance of health through prevention . . . This, I believe, is uniquely the responsibility of public health."***

Public health has always been prevention-oriented. It has always depended on, and usually received, support from the medical community. Together, since 1900, we have seen a 61% reduction in our nation's death rate, much of which is directly attributable to community health activities involving both environmental and personal health programs.

We are now faced with a different kind of challenge, even more difficult to cope with: to convince our people that how they live will determine in large measure what they fall prey to, and when and how they die.

But I am convinced that the solutions are there and can emerge only if we bend all our energies and our convictions toward revealing them. To do so, we in public health will, as we have in the past, look for assistance and support from the medical community.

The physician as a treater of disease is superb; as a teacher, counsellor, advisor, he may achieve even more significant goals toward health care, not just disease treatment.

The point is that health is not, strictly speaking, a function of medicine at all. Medicine begins when health fails.

Government must focus on how people live

So what does this have to do with medicine and health care in Michigan in the years ahead?

Just this, that perhaps the major (or at least co-equal) role of government in addition to its role in medical care should be to initiate more effective programs to prevent illness and maintain health by means of activities that have little or nothing to do with medicine at all, but focus instead on how people live and behave. Because in the final analysis, our behavior has more effect on our physical and mental well-being than all the superb medical and surgical procedures available to us.

Some of the major causes of ill health today are heart disease, cancer, stroke, hypertension, diabetes, accidents, cirrhosis, arteriosclerosis, emphysema and yes, suicide. I would suggest that a drastic reduction in every one of these conditions (with the possible exception of diabetes) is remarkably easy to accomplish. In fact, only four fairly simple goals need to be achieved:

1. All of our people eat optimum levels of the proper foods.

2. All of our people engage in regular physical activities appropriate to their condition.

3. All cigarette smokers quit smoking.

4. All alcohol drinkers stop drinking.

These are simple and quite reasonable goals. If we could achieve them tomorrow, the incidence of the above conditions would drop precipitately, and our citizens would immediately benefit from increased physical and mental health. I doubt whether any physician in Michigan would seriously disagree with that prediction. Yet not one of these four steps involves medicine or medical care!

Beyond medical care is the maintenance of health through prevention. This involves the enormously difficult process of behavioral change. This, I believe, is uniquely the responsibility of public health. It is a task so formidable as to invite skepticism and cynicism, even, if not especially, from physicians, whose training, education, and experience is pragmatic and scientific.

Medicine — medical care — must focus on the treatment of disease processes. Government must work cooperatively with medical practitioners to help assure equal opportunity for medical care — equal quality, equal accessibility, equal availability. Our people have come to demand and to expect this and, together, the private and public sectors are going to provide it as effectively as humanly possible.

There is, of course, a hitch. It is much easier to treat disease than to alter behavior. An injection of penicillin produces quick and tangible benefits; education for health is neither quick nor tangible. A heart by-pass is a tested and well-understood procedure whose success or failure is immediately apparent; proper nutrition is not as well understood and its success or failure is not immediate.

Understandably, therefore, when government must decide whether to appropriate money for kidney dialysis or physical fitness, dialysis will take precedence. In the short run, the payoff is much better. In the long run, and it is a very long run

(Continued on page 266)

as it looks to:

Patric Ludwig, President, Michigan Hospital Association

It would appear that Michigan, in comparison with other states — indeed, even with other countries — has developed one of the finer health care delivery systems available. Most citizens in this state have access to health care and the health care they receive is good.

A contributing factor is that Michigan can offer sufficient financial resources to attract good medical talent and develop good health care facilities. Historically the financing has been relatively stable and sufficient to meet needs and expectations.

Now, however, the financial situation is changing. State government has inadequate dollars to finance the Medicaid program. During the past year it instituted measures to reduce services rendered.

The Blue Cross/Blue Shield of Michigan (BCBSM) program also was threatened with financial insolvency and instituted similar measures — and even though it will be granted a sizeable rate increase, BCBSM finds that the employer groups and unions which pay the BCBSM premiums are objecting.

With such cutbacks in financing, health care providers — particularly physicians, hospitals and nursing homes — find that they must cut back services to Medicaid recipients and BCBSM subscribers. There have been many deliberations by these providers and some cutbacks during the past year.

Mr. Ludwig

Health care increasingly unavailable

Next year, and the year following, if the current financing dilemma persists, could mark the end of a public policy which states that high quality, accessible health care is an inherent right of all the state's citizens.

Unfortunately, the public expects otherwise. And, as financing agents restrict the provision of services, it is providers who earn the public's criti-

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cism. The citizenry does not understand that providers are receiving inadequate resources to carry out what it perceives to be public policy. The public does not realize that financing agents are, in fact, carrying out a policy to restrict health care services.

Actually there is more of a thrust to let the public believe that quality health care services can be readily available (and being readily available presumes no financial impediments to the receipt of care); by increasing regulatory controls over providers to make health care universally available within limited dollars.

Institutional providers view such regulatory controls as an erosion of management prerogatives. Independent practitioners view them as governmental intervention in the practice of medicine. The fact that these views are correct, however, does not necessarily mean that the regulatory controls are wrong.

What is wrong is the application of regulatory controls that are not proven to be beneficial to the patient in a service, quality or cost-effective sense. In Michigan, this is a serious problem because of the number of agencies involved which seem to operate in an uncoordinated fashion.

> ***"Providers . . . must broaden their political constituency and recognize that (it) is . . . consumers of health care"***

Pressures are bringing providers, consumers together

From all of this is emerging a highly significant development. It may, in the long run, accomplish the public policy of making quality, accessible health care an inherent right of the state's citizenry.

Primarily because of the public's attitude, and financial and regulatory issues, health care providers are beginning to work more closely together. They now are getting together more frequently to examine problems of mutual concern. Such discussions will lead to cooperation and will also hopefully lead to constructive change.

Simultaneously, providers are recognizing that they cannot influence public policy by themselves. They must, in fact, broaden their political constituency and recognize that this constituency is the patient population — consumers of health care.

So, while there are more constructive discussions among the providers, there are also more discussions between providers and consumers. No longer do individual provider groups just talk among themselves; rather, they are meeting more and more with other providers and with organized consumer groups.

It is from this kind of movement, whereby consumers and providers of health care services work together to address all the demand and supply issues involved, that one can expect Michigan to continue its development of a system that can satisfy the state's health care needs.

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as it looks to:

Robert D. Coye, MD, Dean
Wayne State University School of Medicine

Right now, only one thing about medicine appears clear. Everything else seems in a state of total confusion.

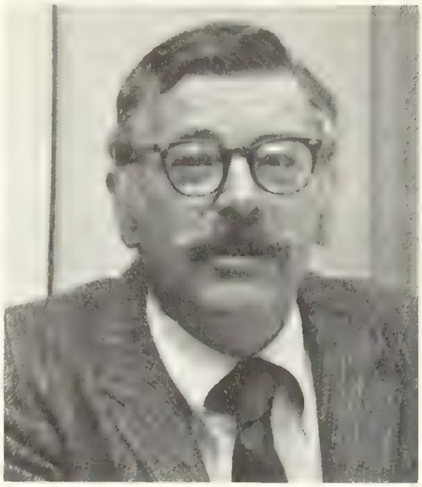
That one thing is that patients don't want to pay for all we doctors and hospitals have to offer in the way of tests, drugs, operative procedures, ancillary services and the like.

Of course, patients could pay for these things, but only by spending less on something else such as maintaining highways or the legislature. The people's preference now is to begin the process of sweating down the health sector of the economy to something less than its present $118 billion size, which is almost 9% of the GNP.

This line of thinking appears to have resulted quite directly from the vaguely-understood but strongly-held belief that all people have a right to good health care. Once it is accepted that everyone has a right to the high quality care now available to some of the people, the cost implications and, as seen in the recent BC/BS agonies, the actual cost results are astonishingly high. As the negotiated benefits for health care increase in union contracts or in contemplated national health insurance plans, the dollars needed to pay for these added services escalate as night follows day.

Assuming, as I do, that there is much that needs to be done to extend the availability and accessibility of health services — that everyone does have some kind of "right" to some reasonable level and quality of health care (although much careful defining of these terms is necessary) — then the immediate and tough question is how can these improvements be made while we are simultaneously trying to reduce costs?

The answer, I believe, is through a better understanding of which parts of our system are cost effective in terms of producing better health and which are not so effective, and then making sure these effective components are available and that the others are not.



Dean Coye

> ***"We must teach ourselves and our students to care for our individual patients, while keeping in mind . . . all other patients."***

It is true that there are only limited studies which enable us to make such decisions with confidence, but surely we know enough to make a strong beginning and set the pace for further development of this approach. One way or another, we must begin to routinely raise such questions as:

—Is it worth the money to do routine skull films on possible skull fractures?

—Of what value is it to test young males for glaucoma?

—What does the CCU really provide that is worth its high cost?

—Is the annual physical exam of proven value?

—At what point do we stop screening for diseases which have a very low probability of occurrence in a given population, or if detected, have a low susceptibility to treatment?

—To what extent are respiratory therapy services overutilized?

—Should I look for another MD associate or two nurse clinicians?

—Should I send my stroke patient for an EMI scan?

By raising these questions, we obviously imply that there is much we do in educating doctors, taking care of patients, in administering hospitals and in watching over the public's health that is more a result of habit than sound evidence of cost effectiveness. It is also true that the public, including the lawyers, has come to expect and place a high value on high technology medical care and a zero defect approach to medical practice. It is questionable that patients would accept a "bread and butter" approach without a shift in their expectations for what they must pay.

The questions further suggest that although our professional training is to do every single thing that could possibly (reasonably?) be beneficial to our individual patient, we realize this approach really can't be applied across the board for all patients, and therefore in a new sense, can't be regarded as quality medicine.

You will also recognize here a disturbing undercurrent suggesting the practice of "herd medicine." Doctor Scott Swisher told me of a young veterinarian he recruited to his Department of Medicine at MSU to help with a research project. This DVM was amazed to see hundreds of students being treated individually by the student health service physicians. In veterinary practice, he said, with that number of sick animals,

(Continued on page 266)

and to:

Donald C. Smith, MD
Director of Michigan Department of Mental Health

Given the problems and frustration inherent in the human services field, you may sometimes wonder what motivates mental health professionals to maintain a consistently high level of performance. Besides fulfilling the basic need to serve, mental health service is exciting for many reasons.

New treatment modalities including modern drugs, more effective group therapy techniques, early intervention and prevention are some of the technological advances which have created an exciting environment and provided the tools required to bring about significant changes in mental health care.

But it is societal changes rather than technological advances which have provided a framework for the most productive use of this technology.

The most recent societal changes have been highlighted by greater public awareness of mental illness and mental retardation. This awareness, coupled with recent court decisions emphasizing the rights of individual clients and patients, has paved the way for achieving an important legal milestone — the enactment of a new mental health code in Michigan.

With enactment of Public Act 258 on August 6, 1975, the Department of Mental Health was carried over the threshold of a new age of change and growth. PA 258, 1975, is the most comprehensive legislation ever passed affecting operations of the Department of Mental Health and allied fields. Under the code, the department is responsible for working with other health care leaders to develop a single, integrated, comprehensive health care delivery system for citizens of Michigan.

Various chapters of the code spell out the responsibilities and requirements of the department for planning, integrating and evaluating mental health services. Other chapters deal with the legal rights of individuals receiving mental health services and obligations of mental health agencies in delivering these services. Perhaps the most important provisions of the Mental Health Code are those that guarantee the legal rights of all Michigan residents to high quality mental health care. The code also charges the Department of Mental Health with ultimate responsibility for delivering that comprehensive care.

In an address to the Michigan Association of Community Mental Health Boards, Governor Milliken emphasized that three health care systems actually exist in this country: institutional, community, and private. The private system has traditionally served individuals who could afford to pay for health care, while institutional and community health care are designed for people with more limited resources.

Doctor Smith

> ***"With continued cooperation of health care professionals . . . we can provide an effective, unified, responsive health care network."***

To fulfill our charge under the Mental Health Code and develop an effective state health care network will require professionals in all three of these separate systems to nurture closer working relationships. It also will require further changes in the statute. On the basis of experience, the department will continue to propose appropriate amendments to achieve the goal.

Michigan's legislative leadership has expressed its desire for all citizens to receive first-rate health care services in first-rate facilities, a philosophy shared and appreciated by Michigan's health care professionals.

However, only by working with our public and private colleagues in mental health and allied fields can the department do its part to guarantee first-rate care to all Michigan citizens in need of mental health services. Private physicians provide a most important link in assisting in this effort, as they usually see and diagnose mental health problems first.

Development of a comprehensive health care system potentially affects all Michigan residents. With continued cooperation and support of health care professionals, both public and private, and leadership and assistance from the Governor and the legislature, we can provide more than just health services. We can provide an effective, unified, responsive health care network.

It is this challenge which motivates health professionals to maintain a high standard of professional care.

and to:

Frederick W. Van Duyne, MD
President, Michigan Medical Practice Board

Doctor Van Duyne

Tumultuous and conflicting political, legal, social, and economic forces have impacted the practice of medicine in the past 10 years. The result has been a perplexing and overwhelming flood of rhetoric, and accusations, followed by a multiplicity of laws, rules and programs.

A calm and objective look reveals one clear message; the physician is being given his last opportunity to be accountable, not only for his own work but also for the work of other physicians.

What has prompted this sudden demand that we undertake this sensitive task? Why are the licensing boards, tissue and review committees of the past not adequate?

We all know the reasons — increased costs, increasingly complex and risky diagnostic procedures and treatments, increasing malpractice litigation, increased patient medical knowledge and increased pressure by consumer groups, press and politicians.

The physician is the individual with the greatest influence over what happens within the health delivery system but along with the doctors' prestige and influence goes accountability.

If physicians are to continue to be responsible for licensure, certification, granting hospital privileges, reviewing, ordering and prescribing, then we have to be willing to look critically at what our colleagues are doing.

We proudly acknowledge the fine achievements of our majority. At the same time we have to take the initiative in identifying, isolating and taking corrective action toward our erring minority.

Many say that the practicing physician cannot and will not accomplish this — that the mechanisms to do so do not exist. Others suggest the job must be done by specially trained "reviewers" either physician or nonphysician, or by computer, laws, rules and regulations, government bureaus, or clerks. Many doctors feel it is too late, that we have already lost the initiative and control to others.

I disagree. We are at the final crossroad. Within a short time we must make the existing mechanisms work effectively or we will lose *control* of them forever.

They include the existing review committees in hospitals, the ethics and review committees of local medical societies, the Judicial Commission of the state medical society.

The mechanism for cost accountability, quality assurance, and utilization review exists within the *PSRO* structure, which mandates local physicians to determine their own standards. Although the future of PSRO as a governmental entity is uncertain, its basic structure and operational principles *do* work. Its techniques *can* be expanded to cover all patients in hospitals and extended care facilities.

> ***"The Physician is being given his last opportunity to be accountable . . ."***

It can impact ambulatory care. It can be financed by private carriers and above all it can be influenced by practicing physicians, to insure that decisions made within its authority are made for medical and not economic or political reasons.

The flexibility and authority of the Medical Practice Board have recently been expanded.

Although an added inconvenience to most doctors, continuing medical education reporting requirements will insure that all doctors pursue timely accredited postgraduate education.

I maintain that the flexible and workable mechanism is present, still incomplete, still untested and unused in many aspects. It can permit doctors at the local level to identify problem doctors and to institute corrective action.

Such action may be the limiting of privileges within the hospital or the removal of a physician from the hospital staff. A physician can be urged to take refresher courses, required to obtain consultation or be monitored by other physicians to upgrade the quality of his medical care. Most often the presence of a peer review capability automatically upgrades everyone's skills.

Local doctors and medical organizations can present the objective data and the peer testimony that can aid the Medical Practice Board in reaching an equitable decision that will protect the public from a sick or incompetent doctor and at the same time allow the accused doctor the greatest opportunity to defend his actions, to have due process of law, and seek rehabilitation, if that is appropriate.

It is not yet a perfect system, but I am convinced that it can work. It must work. It may be unpleasant and time-consuming for those who step up to the challenge.

It can serve and protect the public. It has built-in public accountability and scrutiny while the standard and decision making remain in the hands of the only person qualified to judge a practicing physician — another practicing physician.

Important dates for: Michigan State Medical Society Members

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Medicine in Michigan today as it looks to:

Louis F. Hayes, MD, Group Vice President Professional Affairs, Michigan Blue Cross/Blue Shield

> ***"Are we doing all we can?" The evidence at hand, of explosive utilization and rising costs . . . suggests that we are not."***

Increasing public demand for and professional delivery of medical services, coupled with skyrocketing health care costs, have helped create one of the most critically challenging eras in American medical history.

The problems are not going to vanish with "hocus-pocus." A gaze into the crystal ball does not reveal sufficient cause for healthy optimism. Real problems demand realistic solutions, with everyone pushing in the same direction.

Early this year Blue Cross and Blue Shield of Michigan implemented a temporary cost reduction program, encompassing administrative and payment efficiencies, to help restore a sound corporate reserve level.

Our organization, of course, is not alone in its concern for the future of health care. Nor can we be held solely accountable for solutions the industry so desperately needs. For example, the state insurance bureau, in a shortsighted effort to regulate costs in the recent past, authorized rate increases far below our accurate estimates of what was needed. Providers of health care are justifiably concerned about inflation, and many are finding our "cost caps" rather unpopular. Subscribers and groups are also feeling the pinch, and they are telling us what they think.

The challenges facing the medical profession are advanced technology, increasing demands from patients, escalating services and fees, and the appropriate distribution and use of manpower.

Advanced technological procedures — automated laboratory analysis, radioisotopic procedures, and computerized axial tomography, to name a few — are effective though high-priced breakthroughs. They also have created a dire need and responsibility for physicians, as well as others, to allocate costly equipment and technical manpower.

Can we honestly afford the luxury of too many of the same expensive machines or services concentrated in a small geographic area?

Physicians make decisions directly affecting utilization of benefits and subsequently higher rates for coverage. It seems likely that "defensive medicine" is a convenient rationale for some doctors to order tests inappropriately. By the same token, a patient's demand for medical services is not a reason for physicians to automatically order them.

In the past, doctors have been generally cooperative in fee restraint. Yet the trend toward explosive utilization and the lesser trend in escalating fees over the past five years makes one wonder if doctors really are comprehending and addressing the "cost versus benefit" problem with sensitivity and prudence.

Back in 1964-65, while serving on the MSMS Council, I was urging my peers to take a good look at the distribution of physicians. Today, many of us are still questioning whether there are enough doctors in primary care, whether there are too many specialists, and whether the current location of physicians adversely affects the availability of health care for segments of Michigan's population.

Appropriate use of health manpower is in the best interests of all physicians. Among new paraprofessionals on the scene is the physician's assistant. While this development has the capacity to increase availability of service, care must be taken that reimbursement for such service is not overly costly. We must keep in mind an AMA ethic — that physicians should not profit from the labor of others.

We are all aware of the government's expanding role in the financing and control of the health care industry. While we go about our business, the government is assuming a more active posture. Some of us may not like the idea of public control over our destinies. As members of the private sector, we must demonstrate our own effectiveness.

The title of this article asks, "are we doing all we can?" The evidence at hand, of explosive utilization and rising costs — whatever the rationale — suggests that we are not. There is no better time and no better opportunity for the public, hospitals, physicians, and Blue Cross and Blue Shield to address and resolve these challenges.

Doctor Hayes

to:

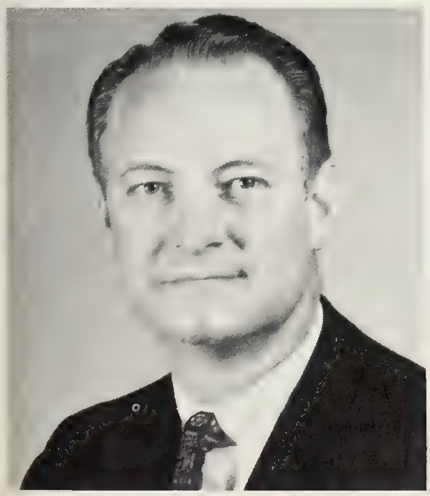
Lee B. Stevenson, MD, Coordinator
Michigan Council of Specialty Societies

Health care in Michigan is excellent in this spring of 1976. But the maintenance and improvement of this quality is challenged in many ways. Unless the challenges are met and controlled, the FUN or pleasure one derives from the good practice of medicine will be stripped off and blown away.

The medical professional liability mess is the largest challenge, and in spite of all the work the Michigan Legislature did to correct factors affecting the problem, the key issue — the medical malpractice premium amount — has not been corrected. Premiums for physicians and hospitals continue to rise 10 to 20 times faster than the general inflation.

> ***"Our real concern is the patient . . . and the price she must pay in dollars and well-being for quality health care."***

And with premiums starting at $10,000 (a modest example) how many young physicians will be starting new practices in the surgical specialties? How many older physicians who would prefer to slow down or taper off from busy practices can afford to do so? How many part time physicians, can afford to pay the ridiculous amounts? How many will or can afford to "go bare," practicing without insurance? In 1975-1976, many practices have been closed with physicians seeking other employment — in emergency rooms, industrial offices, and early retirement. Losing these experienced practitioners, even to a different field of medicine, increases the expenses to everyone.



Doctor Stevenson

Additional expenses have been added to physicians in Michigan with the poorly conceived continuing medical education program which was put into effect before the regulations were designed.

Who will pay for this effort to educate the *few* physicians who do not know about modern medicine? Answer: the burden will fall on the 75 to 80% who already more than meet the legislated requirements.

None of the steps involved in carrying out the new program is free. The only redeeming factor is the possibility that physicians will learn something useful at the programs they are legislated to attend — and to pay for! Remember this is one of the ways to identify the occasional physician who abuses "the system" by overcharging or overutilizing expensive medical facilities, equipment, or laboratory studies as opposed to the physician who occasionally commits these sins.

A new gimmick adopted by Blue Shield in Michigan and elsewhere after pressure from organized labor — the professed experts in everything according to their spokesmen — is presurgical screening for "elective surgery." Today this is described as a "voluntary consultation," paid for by Blue Shield, the organization that tells the impotent Insurance Commissioner of Michigan it will be bankrupt within a year without a 35% premium increase! In my opinion, the money and time spent to design, implement, fund, monitor and report this "study" could have been better utilized in another premium saving way. I predict that the cost will far outweigh any benefits to Blue Cross-Blue Shield, labor, medicine, and our public — the paying and paying and paying consumer.

Cuts in third party payments to physicians and hospitals at a time when everyone knows medical expenses are rising faster than other components of our economy — the malpractice premium alone accounts for much of this — will NOT cut costs to the consumer. The patient pays! Such cuts treating the symptom without affecting the disease are well known to medicine. Hospitals and physicians can only cut services as dollars dwindle. This ultimately means unemployment.

In the April 2 *Detroit Free Press,* Dolores Katz brings to our attention that Michigan lost 168 practicing doctors in 1975. The source, the Michigan Health Council, blames (1) High premiums of malpractice insurance, (2) Discriminatory effect of Michigan's Single Business Tax Law, and (3) Regulation of CME.

Public regression in health care must be avoided.

Physician-led plans and programs have no enforcement back-up — they are voluntary, and as a result of rational explanation and discussion. But any plan committing an individual or institution to change is a threat. The many hours and discussions about "better utilization of obstetric beds" to increase efficiency and promote economies had some flowers in spite of the storms, but very few apples matured. Another example is regionalization of medical care, very slowly accepted in the medical community since it is a threat, but an opportunity and a necessity to improve outcome of medical care in Michigan.

If this reflects self-pity for the profession, so be it! But our real concern is the patient — our "consumer" — and the price she must pay in dollars and well-being for quality health care. Here the real pity should be for those trapped on fixed incomes in an inflationary economy where health care is only *one* of many crises.

and to:

Jay G. Endsley, Director
State Office of Health and Medical Affairs

While the current chaos with the state's Medicaid expenditures is a many-faceted problem, it is, in the simplest terms, a planning failure.

It is planning failure because, in a time of plenty, additional benefits were added to the program without consideration of the future impact of these benefits. The state simply did not plan for increase in utilization or rising costs of these services when changes were made in the program.

In addition it is well understood that Michigan's economy in particular presents the difficult paradox wherein the state's resources to reimburse for services provided are at a low when demands are at their highest. Little attention was directed toward how the state would finance its way through the recession period that is now gradually improving.

The centralization of health planning, policy, and budgeting within the Office of Health and Medical Affairs should provide the best available organizational strategy for meeting such demands in the near future.

In May 1974, in what must seem like a perpetual reorganization, the OHMA assumed responsibility for final preparation of the budgets for the Department of Public Health and the Medicaid portion of the Department of Social Services.

This assumption of responsibilities is predicated on two observations: (1) the National Health Planning and Resources Development Act of 1974 places strong emphasis on the need to contain the escalating costs of health care and, (2) there needs to be a strong link between health policy, long-range planning for carrying out that policy, and the annual health budget of the operating agencies.

One can debate (and many do) the philosophical pros and cons of combining planning and budgeting within a single agency. But there is little question there must be a strong, direct tie between planning for health care and the allocation of resources to fulfill those plans to, therefore, provide an adequate level of services to residents of the state.

The overriding concern of both public policy and private action in Michigan is increasingly to brake the rapid escalation of real expenditures on health services. For years, the increased use of the state's health care resources has outstripped the overall growth of the economy.

However, the rate of cost increase is not the only health care problem facing the people of Michigan. The state is plagued by other inadequacies in its system of health care. For example, there is a significant maldistribution of health services with some areas comparatively richly endowed in relation to need for care and other parts not nearly so well supplied.

> ***"The fundamental challenge now is to develop new processes for managing the limited resources available to provide health services . . ."***

Thus, while the state as a whole has an average of 433 general hospital beds per 100,000 population, comparing favorably with the U.S. average of 453, the area-by-area variation around the average is substantial. For example, the Saginaw-Bay City area enjoys a bed-to-population ratio about 20 percent above the state average, and the Ann Arbor area, admittedly a referral center, has over twice as many hospital beds in relation to population as the state overall. In contrast, Monroe County, has only about half as many general hospital beds in relation to population as the state average.

Michigan is not unique in having such problems. Most other states, and the country as a whole, share them. The picture they present is one of a health care system in which the processes to distribute resources and develop service programs are not adequate to provide quality service equitably and with reasonable efficiency.

This unfortunate condition was supportable so long as the cumulative impact of inefficiencies, coupled with still rising public expectations, had not outstripped the availability of resources to meet demands. However, we believe that in Michigan, at least, this point has been reached.

Thus, the fundamental challenge now is to develop new processes for managing the limited resources that will be available to provide health services so they achieve the greatest possible impact on the well-being of the state's citizens.

The first step will be the development of a comprehensive health strategy. Obviously the nature of the state's health care system cannot and should not be changed overnight. Rather, action is needed to identify the leverage points in the management of health care resources and to develop with careful expedition new processes designed better to achieve the goals of quality, equity, and efficiency in the provision of health services.

The underlying philosophy being developed in Michigan for managing the state's health care system has two major elements. The first is that the priority commitment must be to contain the rate of expenditure increase, as the current rate of increase is jeopardizing all other goals.

The second element is that an overall strategy will have a number of components. No single instrument of public policy can be expected to achieve its multiple goals. Indeed, some features will be aimed at ensuring that expenditure containment is not achieved at the expense of inappropriate reductions in service availability or quality.

We believe that the overall effort in Michigan must encompass state and regional health planning, utilization review, licensing, accreditation, and other quality assurance mechanisms, and changes in the basic incentives for distributing health care resources and

(Continued on page 266)

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Mr. Endsley

services rationally. The challenge is to develop a mix of these management programs that will achieve needed care of appropriate quality at an affordable cost.

This program mix is what we mean by the term "comprehensive strategy."

Concentrating public policy attention on developing processes to contain the rate of increase in expenditures when there clearly are major gaps in health services in relation to people's expectations, and even their needs, is potentially an unpopular position. Nevertheless, we believe the rate of increase in health care cost has become so substantial that it overrides the other problems. Moreover, gaining control of the rate of expenditure increase may well offer the only grounds on which other problems can be tackled. For example, within the severely limited resources available to the state for its Medicaid program, failure to define and deal with the perceived issue of "unnecessary" surgery will mean that resources will not be available to increase the quantity of "appropriate" surgery or services which now have low availability.

Thus, concentration on expenditure containment represents the necessary starting point for achieving other health care system goals.

We believe that failure of a health care system management improvement effort to come to grips with the need to manage total volume of services, and specific elements, will inevitably lead to failure in providing needed services at an affordable cost to society.

DEAN COYE/*Continued*

you would autopsy a few and treat the rest on the basis of the autopsy findings!

Garrett Hardin probed this question in an article entitled the "law of the commons." He postulated a common pasture available to all of the herdsmen of the area with no limits to the number of animals each herdsman might place on the commons. A point is reached at which the further addition of animals reduces the available grazing to an uneconomic balance for all of the animals taken as a group. But it never reached a point where it was clearly uneconomic for one herdsman to add one more animal.

We face a very similar quandary. We can't have "quality" medicine for our individual patients and "quality" medicine for all patients unless we pay an unacceptably high price or redefine our concept of quality. This redefining of quality is already under way in the form of PSRO and other not-very-welcome oversights.

Physicians in general are deeply disturbed by this approach for quite understandable reasons. Probably the most important is that our training in the classic university hospital setting was to do exhaustive differential diagnostic work-ups and in essence exclude all diseases no matter how costly or remote the possibility. Woe to the 3rd-year clerk who failed to do a rectal on a 24-year old male admitted for strabismus! Those diseases not excluded were left as diagnoses and were treated with every resource available, again discounting the costs and in many instances the wildly improbable prospect that what therapeutic regimens we were carrying out would do any long-range good. It was and still is a satisfying ethic of devotion to an individual patient.

But something was missing: While doing all possible for the sick kid in bed #4 with the H. flu meningitis, we never gave a moment's thought to the many other children we didn't see, and who were not getting the best possible care.

That seems to me the essence of needed change if we are in the future to have what we can call quality medicine at a reasonable cost. We must teach ourselves and our students to care for our individual patient, while keeping in mind at the same time all other patients.

Perhaps the day will come when the faculty physician will be revered by his students and given the Clinical Teacher of the Year Award for being "the least conspicuous consumer of scarce resources per patient effectively relieved of significant health care concerns." Hoo boy. That would be some university hospital.

DOCTOR REIZEN/*Continued*

indeed, physical fitness is probably the better buy even on a cost-benefit basis.

We must live with political reality, too

The excruciating dilemma is of course that such a choice should be necessary at all. Both are essential and neither should be undone. But political realities are not, necessarily, synonymous with the realities of health, and we must live with both.

Almost everyone agrees that equal opportunity for health should be a basic right of our people. To realize that right requires various kinds of governmental actions, some of which are now in formative stages. One of the actions to come in the near future will undoubtedly be some form of national health insurance.

But when it comes — in whatever form — it will involve only a mechanism to pay for the treatment of disease. It will be national disease payment insurance — not health insurance. I do not mean to derogate the importance of, or necessity for, such insurance. I do, however, want to emphasize that it will impact primarily on sickness and will be aimed at health *restoration* rather than health *maintenance*. These are quite different concepts of which only the latter should, semantically at least, be considered health care.

Government — federal, state, and local — is now and will increasingly be involved in sickness treatment by payment mechanisms, surveillance, and regulation, at the least. The more important role government may play, however, is in health maintenance which in general is not a medical problem at all.

welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Bharat L. Agrawal, MD
54 Bronson Medical Ctr.
Kalamazoo 49006

Ronald J. Barnhart, MD
2909 E. Grand River #204
Lansing 48912

Brian B. Bojesen, MD
83 E. Avon Rd.
Rochester 48063

John F. Butzer, MD
1900 Wealthy St., S.E.
Grand Rapids 49506

Shen Eng Chen, MD
Riverwood Comm. Mental Hlth. Ctr.
St. Joseph 49085

Bernard Dunne, MD
997 Agard St.
Benton Harbor 49022

Domenic R. Federico, MD
2203 Union Ave., S.E.
Grand Rapids 49507

Dennis C. Herzog, MD
1116 N. Bond
Saginaw 48602

Paul J. Hletko, MD
1521 Gull Rd.
Kalamazoo 49001

Gary D. Hood, MD
G-5067 W. Bristol Rd.
Flint 48507

Ruth B. Hoppe, MD
Dept. of Med. MSU
East Lansing 48824

Robert E. Hunter, MD
2107 Aurelius Rd.
Holt 48842

John D. Karakitsos, MD
1400 E. Michigan #203
Lansing 48912

Douglas A. Krause, MD
302 Kensington Ave.
Flint 48502

Wm. H. Middleton, MD
122 Grant St.
Niles 49120

Robert H. Mortimore, MD
801 Sandlyn Dr.
Lansing 48910

Sami Mounayer, MD
3535 W. 13 Mile Rd. #601
Royal Oak 48072

Panayotis Pesaros, MD
Wm. Beaumont Hosp.
Royal Oak 48072

Obaid Rehman, MD
1500 Weiss St.
Saginaw 48602

Charles H. Rhodes, MD
2 Hospital Dr.
Berrien Center 49102

Susan L. Scheurer, MD
522 N. Jenison
Lansing 48915

Richard L. Schloemer, MD
250 Bronson Medical Ctr.
Kalamazoo 49006

Purnima B. Shah, MD
3601 W. 13 Mile Rd.
Royal Oak 48072

Nigel J. Strickland, MD
30910 Franklin Rd.
Franklin 48025

Paul K. Tam, MD
777-D Riverview Dr.
Benton Harbor 49022

Verna Jean Turkish, DO
21 S. Prospect
Ypsilanti 48197

Rogelio C. Verzosa, MD
5730 W. Dunbar
Monroe 48161

Charles M. Watts, MD
St. Joseph Mercy Hosp.
Ann Arbor 48104

Stephen E. Werner, MD
7138 Glenburnie
Clarkston 48016

Milton Zaagman now independent agent; employed as lobbyist for MSMS

The Michigan State Medical Society has signed a contract for lobbyist services with former staff member Milton Zaagman, who is now free to act as an independent lobbyist agent for multiple clients. Additional clients must be approved by MSMS under the terms of the new contract.

The arrangement was sought by Mr. Zaagman after a year's service with MSMS. Seeking more lobbying work, he proposed the independent agent arrangement which was approved by The MSMS Council.

Associations contracting for services with such independent lobbyist agents is an accelerating trend.

The MSMS Committee on State Legislation and Regulations, recognizing the benefits of the trend, recommended the new arrangement for MSMS.

The arrangement, under which Mr. Zaagman maintains individual liaison with members of the legislature to foster MSMS objectives, is cost effective and politically effective.

Mr. Zaagman is in daily contact with MSMS Government Affairs staff.

meetings

See Listing of Category I Programs, page 245

May 19 – Annual meeting, Michigan Allergy Society, contact: B. David Wilson, MD, Sec., MAS, 4615 W. Main St., Kalamazoo 49007

May 19 – 108th Annual WSU Medical Alumni Reunion Day, Michigan Inn, Southfield, contact: Don Burkholder, PhD, WSU University Relations-School of Medicine, 540 E. Canfield, Detroit 48201

May 27-28 – Committee Meeting on Maternal and Perinatal Health at Gull Lake MSU Conference Center, contact: Helen Schulte, MSMS Headquarters

June 1-3 – Annual Meeting, Michigan Chapter American Academy of Pediatrics, Bay Valley Inn, Bay City, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48024

June 2-3 – Practice Management Workshop jointly sponsored by MSMS and AMA, Michigan Inn, Southfield, contact: John Anthony, MSMS headquarters

June 2-4 — Annual meeting, Michigan Public Health Association, Grand Hotel, Mackinac Island, contact: LaRue Miller, executive director, MPHA, 403 Seymour, Lansing

June 11-13 – 15th Annual Medical Symposium, Kidney Foundation of Michigan, at the Hyatt Regency Hotel, Dearborn, contact: Gerald A. Rigg, MD, Wayne County General Hospital, Eloise, Michigan

June 15-18 – Symposium on Childhood Deafness, sponsored by Central Michigan University, at CMU, contact: Mr. Lynn Kindel, Off-Campus Education, CMU, Mt. Pleasant 48859

June 17-19 – Annual Keyport Trauma Symposium, sponsored by the Michigan Committee of the American College of Surgeons, at Otsego Ski Club, Gaylord, contact: B. E. Henig, MD, 308 Michigan Avenue, Grayling 49738

June 24-25 – Professional Health Practices and Their Impact on Aging, sponsored by Michigan Office of Services to the Aging, co-sponsored by MSMS, at Lansing Hilton Inn, contact: Paulette Whan, 3500 North Logan, Lansing 48913

June 26-July 1 — AMA Annual Convention, Dallas

July 11-16 – Short Course, "Community Relations for Health Services Administration," sponsored by University of Michigan School of Public Health**

July 17 – The MSMS Council, Sugar Loaf Village, Cedar, contact: Warren Tryloff

July 25-27 – Bi-Annual Meeting, Michigan Academy of Plastic Surgeons, Grand Hotel, Mackinac Island, contact: David B. Hawtof, MD, 15901 West Nine Mile Rd., Southfield 48075

July 25-30 – Short course, "Supervision of the Health Field: Theory, Process, Practice," sponsored by University of Michigan School of Public Health**

July 29-30 – Annual Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City, contact: Laurence P. Skendzel, MD, Munson Medical Center, Traverse City 49684

July 31-Aug. 4 – Annual Meeting and Scientific Assembly, Michigan Academy of Family Physicians, Holiday Inn, Traverse City, contact: Rita Feldkamp, Exec. Sec., 933 Wing St., Plymouth 48170

August 8-13 – Short Course, "Problems in Planning and Evaluation," sponsored by University of Michigan School of Public Health**

September 2-15 – MSMS/INTRAV trip, "Western European Air/Sea Cruise, contact: Marcelyn Ireland, MSMS headquarters

September 18 – September Seminar "Lesions of the Bone," Michigan Society of Pathologists, St. John Hospital, Detroit, contact: Robert Hendrix, Dept. of Pathology, University of Michigan, Ann Arbor 48104

**Contact: Dr. Anna B. Brown, Director of Continuing Education, 3550 School of Public Health I, The University of Michigan, 109 S. Observatory Street, Ann Arbor 48109

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[1] Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976.

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commentary

Medicine itself can cut costs

By Raymond A. Sokolov, MD
Farmington

Those of us who serve on ethics committees have become painfully aware of the gradual penetration of the commercial world into our profession. Whereas once we dealt mostly with doctor-to-doctor or doctor-to-patient relationships of a medical nature, today we deal to a great extent with the problems of professional corporations, advertising, lay-controlled clinics and laboratories, excessive charges and commercial exploitation of governmental and other third party payors.

Not that this is all bad. There is nothing shameful in that doctors now enjoy more leisure, more time for family life and recreation and more financial security than they did in the days of the horse and buggy.

But there are strong signals that the feudalism may have swung too far, that we may indeed be killing the legendary goose. Osler would have been wide-eyed in disbelief could he have seen a recent network TV program which glorified an unabashed, proud, solo practitioner who had learned to extract an annual income of a half million dollars out of Medicare, Medicaid and Blue Shield and was demonstrating how to use this affluence.

Wide publicity was given a recent governmental study proclaiming that our profession was performing thousands of unnecessary surgical procedures at a cost of billions of dollars and thousands of lives. Though we may question the manner in which this study was done and we may disagree with the statistics, there is an element of truth here, perhaps larger than we realize, and one which is eluding our present self-policing methods.

Nor are the surgeons alone at fault. There is a burgeoning boom in laboratory work. Sparked by the permissive availability of funds from government, there has grown up a nation-wide establishment, lay-controlled, of commercial diagnostic medical laboratories which advertise, promote, solicit and use every commercial stratagem to create profits out of illness.

Some temptations

There is a great temptation, difficult to resist, to order "everything in the book" as frequently as possible. This not only adds to the doctor's income, but also gives the impression that he is "thorough." More than that it helps the doctor feel that he is forestalling the possibility of a malpractice suit. Worthy objectives all, but what a devastating effect on the cost of medical care.

As medical technology progresses, the laboratory tests become more sophisticated and more expensive. Patients are impressed by the new and the spectacular. The doctor who is slow to embrace innovative procedures, which patients learn about from the media and from other patients, will soon be out of business. And since Big Brother is paying for it anyway, what the hell!

How then do we get off this escalator? Recent proposed legislation to remove restraints on medical advertising would make matters worse, not better. Why aren't our self-policing methods handling these problems? Haven't we always maintained that doctors can best police their own?

Utilization review committees are bogged down in controversy and may never get off the ground. Even should they someday become operational, the likelihood of yet another bureaucratic quagmire looms. It would be as though we were trying to quell an inferno in the Empire State Building with a committee wielding water pistols on every floor.

Ethics committees lack the time, the investigatory personnel and the necessary skills to remedy the problem. Furthermore they deal, of necessity, with one individual at a time and have no role in establishing policy.

Medical practice boards, possessing sharper teeth than ethics committees, still are similarly handicapped.

Must we then wait until an aroused public pressures the federal government to a drastic solution? I should think not.

Here is a role for organized medicine, preferably at the state level. A profession with brain power adequate to overcome most of the plagues that beset our forebears surely is wise enough to find a cure for a virus which threatens its historic role as a proud profession.

Some suggestions

Our leaders should take a week off and constitute themselves as a think-tank, a constitutional convention as it were, and come up with a creative, imaginative plan that we can ourselves make work. In advance of their meeting they should issue a call for ideas and suggestions from all of us. For openers here are a few of mine:

1) No physician may receive payment for a diagnostic laboratory procedure which he himself has requested, nor may he share in any way in the payment for such a procedure.

2) Elective surgery may not be performed when the physician performing the surgery is the sole judge of whether the surgery is appropriate or indicated.

3) Diagnostic laboratories may not be operated for profit nor controlled by commercial interests. They must conform to the same regulations that govern professional relationships as to advertising, solicitation, referrals, kick-backs, etc. They should preferably be under the aegis of medical schools, non-profit broad-based community hospitals, health departments or recognized pathologists, bacteriologists, chemists and radiologists.

Let's not leave cost control to the federal government

By John J. Coury, MD
Chairman, Michigan Delegation to the AMA

Whenever I hear or read of persons advocating government management of more health care, I wonder how effective the federal government can be in cost management.

How well does the government manage the postal service? Or the Social Security Administration?

How blameless is the government for the abuse of Medicaid?

Did you catch the report by the general accounting office (GAO) comparing the SSA performance with that of four private insurance companies in dealing with the institutional providers of Medicare service?

The average cost — excluding audit — of a bill processed by SSA's Division of Direct Reimbursement (DDR) was $12.39 in 1973, compared with $7.31 for Traveler's, $7.28 for Mutual of Omaha, $3.81 for Blue Cross of Chicago, and $3.55 for Blue Cross of Maryland.

GAO found that "higher salaries and lower productivity appear to be major reasons for the high costs of the Division (DDR), which, unlike the private intermediaries, had no production standards." DDR's annual compensation exceeded that of neighboring Maryland Blue Cross by 25% for accountants and auditors, 51% for claims examiners.

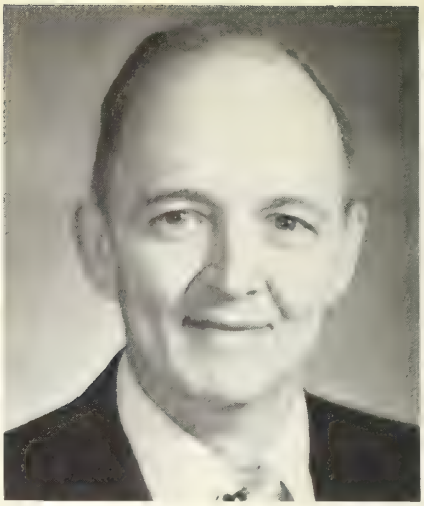
"Despite DDR's higher costs," the report continued, "it generally took longer than other intermediaries to pay bills and settle with providers."

HEW called the GAO report outdated. But DDR's lack of cost data (GAO had to develop them) could explain the delay.

The debate contrasting government and non-government operations in the health field surely will go on during this election year.

Congress ought to think hard about the report from its fiscal watchdog. And think hard about making SSA the health-insurance administrator for the public at large, as proposed in such legislation as the Kennedy bill.

Doctor Coury



Doctor Lukens

(Excerpted from President's Message by Jack G. Lukens, MD, in current issue of Kent County Medical Society Bulletin)

The AMA needs you!

To non-members of the AMA:

Does medicine need a national organization to represent physicians in health and legislative areas? Should we be addressing ourselves to this goal? Are AMA critics willing to put forth some effort in this matter?

Should the AMA remain our national organization and if so, how does it need to be changed?

There seems little dissension among physicians that government is progressively controlling medicine and its members, and we need to have input into these decisions. Can we get this by individual letters or is a national organization more effective?

Legislators and other leaders indicate the AMA lobby is quite influential.

Lobbying is designed to promote self-interest, but if an interest includes the welfare of our patients, as we all claim, then our lobbying should be beneficial. AMA lobbyists provide legislators, locally and nationally, with hard data.

Doctors need an association which has an organized input in government. The organization needs more members with both financial and personal commitments. Submit your criticisms of the AMA and what changes you require before you would join, so we can discuss them with AMA officials. *WE* NEED YOUR SUPPORT!

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Our only elected MD official talks about political involvement

(Editor's Note: Here is an interview with Jack Stack, MD, of Alma, member of the MSU Board of Trustees. He is the only Michigan physician holding an office as the result of a statewide election: Doctor Stack was nominated by the Republican Party Convention in 1972 and then was elected the following November. His term of office will run until January 1, 1981.)

Question: Why should a physician be involved in politics?

One physician said to me when I asked him to contribute to MDPAC, "Why must I be involved in politics? Why is it not sufficient that I just practice good medicine?" My answer to him was that we cannot practice medicine in a political vacuum. Decisions regarding public policy are being made every day which affect our patients, our offices, our hospitals, and our profession.

If I may paraphrase Plato from "The Republic" — the proper punishment for the wise man who refuses to be involved in politics is to be ruled by unwise men.

Question: How about listing some of the areas of medical practice that you think have some political overtones or dependence?

There are many issues involving medicine and society in which some component of the solution is within the political process.

The medicare debate of the Sixties and the national health insurance debate of the Seventies is in part a political process by which society will indicate what changes are wanted in the delivery and payment of health services.

The creation and support of medical schools is an intense political process. As you know, the creation of both the College of Human Medicine and the College of Osteopathic Medicine at Michigan State University were the results of long periods of debate and evoluation of public policy through the political process.

Support of basic and applied medical research is essential in our society and is intensely political within the universities, foundations, and government.

There are children contracting 18th century diseases such as diphtheria and TB, women delivering without prenatal care, poor people unable to obtain basic preventive care, children chronically malnourished, prison inmates without basic physical and mental health services, not because we don't know enough, not because the medical profession is unwilling to serve, but because as a society we do not have the public policy . . . the political commitment to resolution of these problems. As physicians we have much to contribute to that debate and to the establishment of public policy.

Other obvious areas of debate and political involvement include professional service review organizations, health maintenance organizations, comprehensive health plannning, medical licensure, health education and our society's total commitment to meeting the health manpower needs of the state and nation. As we all know, the solution to the medical malpractice issue does not lie in our offices and hospital alone, but also in the political process.

Question: How did you, Doctor Stack, get interested in politics?

In 1966, before I had been in family practice two years, I decided that I wanted to be able to have a say about what happened in the political decisions of our day. As many of you know, I became involved in partisan politics, in issues political, in medical society politics, and other areas of public service such as the Michigan Mental Health Advisory Council, the prison health problem as well as the Board of Trustees at Michigan State University.

It is my hope that those who know me well will be able to say, "He is a good father, a good husband, a good friend, and a good physician." But it is also my hope that some may say, "He is a good politician."

Question: Does the physician have any special obligations to contribute to the political legislative process? Why are you serving on the MSU Board of Trustees?

Most of us have been educated in public institutions and to a great extent at public expense. We are given by society one of the most valued privileges our society can confer — the privilege to practice medicine and influence in a major and intimate way the lives of thousands of people.

When I was ready to attend college, MSU was there ready to serve me, not through any virtue of mine, but through the efforts of college presidents and teachers, taxpayers, legislators, and politicians.

We must understand that institutions such as Michigan State University have a life of their own. They are fragile and must be nutured, protected, loved and disciplined. Because MSU and the U of M were ready for me and served me well I believe I have an obligation to repay that which was invested in me. I believe I have a debt of service. I am fortunate and grateful to be able to serve as a trustee of such a great institution as Michigan State University.

Question: I understand you were impressed at a recent MSU commencement by the comments made about politics by the commencement speaker, Katherine Graham. What did that nationally known Washington Post executive say?

In the commencement address to the June graduating class of 1975 at Michigan State Univeristy, Miss Graham said, "Politics is the means of resolving — peacefully — conflicts among legitimate and worthy claims on public institutions and resources. As a method of governing, democratic politics is in fact one of the most demanding of all human arts. It requires reaching some just accommodation among interests that can never be wholly reconciled. It challenges peoples' skills of analysis, persuasion and communication. Beyond that, politics asks for great compassion, an active regard for diversity even when diversity proves inconvenient.

Politics asks for the ability to tolerate frustration, cumbersome procedures, and all the lack of clarity and finality inherent in the workings of a free society. And precisely because it is so imperfect and so dependent for its successes on a capacity to hear people's voices, politics — the politcal method — is humanizing. For a true politician there are people 'out there' to be accommodated, won over, dealt with fairly, argued with, explained to and, above all, learned from."

Question: Any closing challenges, Doctor Stack, for MSMS members?

As physicians we have a unique opportunity to influence the development of public policy. We are in positions of respect in our communities. We are well educated and knowledgeable about human needs. Each of us must serve in whatever capacities of time, energy, and skills to help preserve and protect our Republic, our institutions, and our profession.

It is my opinion that we must all do our share in the task of resolving issues of conflicting interest, of building and protecting our institutions, of serving our people and of keeping the Republic.

As Justice Oliver Wendell Holmes, Jr., once said, "We must be involved in the action and passion of our times or we shall risk being judged not to have lived."

Doctor Stack

We need a way for individual MDs to be heard

By James S. Todd, MD
Ridgewood, NJ

Doctor Todd

Doctor Todd is with the AMA Task Force on Communications

There is a peculiar tendency for physicians to reject leadership.

More than any other group, physicians by their very nature are reluctant to delegate authority, and the result is a splintering of the profession into ever smaller groups each trying to maintain its own concept of individuality.

The failure to recognize the depth of this problem of individuality, and to compensate for it, has hindered severely the status and progress of organized medicine.

You know from the moment we enter medical school, maybe even before, we are taught to be self-sufficient individuals, make our own decisions, suffer the consequences of these decisions, and perhaps most dangerously expect everyone else to accept our evaluations, and act according to our directions.

We need a program where the rank and file member, indeed, the nonmember, may feel he is a part of organized medicine, that his opinions are being heard and perhaps equally important, whereby he may hear of the reasons why organized medicine does as it does in his behalf.

Overhead Cost of Medical Practice Increasing Significantly

The tables at the right show that physician expenses are growing at a much greater rate than either gross revenue or net income. For example, in all specialties, costs have gone up 73.6% in this six year period of time compared to a net income rise of only 39.2%. Generalists have experienced a much smaller increase in net income (31.0%) compared to the surgeons' 44.6% increase. Generalists' expenses as a percent of gross revenue showed a 17.0% increase; surgeons, 10.4%; and all specialties, 11.7%. →

Table I
Financial Components of Medical Practice

All Specialties	*1968*	*1969*	*1970*	*1971*	*1972*	*1973*
Gross Revenue	$54,556	$60,951	$67,349	$73,801	$78,123	$82,481
Expenses	19,046	21,225	25,560	28,523	30,883	33,066
Net Income	35,510	39,726	41,789	45,278	47,240	49,415
General Practice						
Gross Revenue	$53,298	$58,906	$59,578	$71,360	$75,369	$78,574
Expenses	20,990	24,172	25,719	31,537	34,092	36,238
Net Income	32,308	34,734	33,859	39,823	41,277	42,336
Surgery						
Gross Revenue	$62,986	$74,323	$79,258	$86,454	$91,080	$96,706
Expenses	22,332	25,475	28,557	32,409	35,039	37,932
Net Income	40,654	48,848	50,701	54,045	56,041	58,774

Table II
Percent Increases

All specialties	*1968-1969*	*1969-1970*	*1970-1971*	*1971-1972*	*1972-1973*	*1968-1973*
Gross Revenue	11.7%	10.5%	9.6%	5.9%	5.6%	51.2%
Expenses	11.4	20.4	11.6	8.3	7.1	73.6
Net Income	11.9	5.2	8.3	4.3	4.6	39.2
General Practice						
Gross Revenue	10.5%	1.1%	19.8%	5.6%	4.3%	47.4%
Expenses	15.2	6.4	22.6	8.1	6.3	72.6
Net Income	7.5	-2.5	17.6	3.7	2.6	31.0
Surgery						
Gross Revenue	18.0%	6.6%	9.1%	5.4%	6.2%	53.5%
Expenses	14.1	12.1	13.5	8.1	8.3	69.9
Net Income	20.2	3.8	6.6	3.7	4.9	44.6

Table III
Expenses as a Percent of Gross Revenue

	1968	*1969*	*1970*	*1971*	*1972*	*1973*
All specialties	35.9%	34.8%	38.0%	38.6%	39.5%	40.1%
General Practice	39.4	41.0	43.2	44.2	45.2	46.1
Surgery	35.5	34.3	36.0	37.5	38.5	39.2

MSMS Bureau of Economic Information
January, 1976

Health Care Delivery to be studied by new U-M center

Health care, its delivery and ways of improving both will be the subjects of an extensive study to be carried out by a new health sciences research center at The University of Michigan under the direction of Beverly C. Payne, MD. It is one of five such centers around the nation supported by a $1,250,000 grant recently approved by the Department of Health, Education and Welfare (HEW).

Doctor Payne has resigned his assistant deanship at the U-M Medical School to take the new post.

Planned to run for five or more years, the project will use the Washtenaw County area as a "laboratory" for the development of detailed information on the population's health status, the effectiveness of the area's health care delivery system and ways of improving both through changes in the attitudes and behaviors of both providers of care and its recipients.

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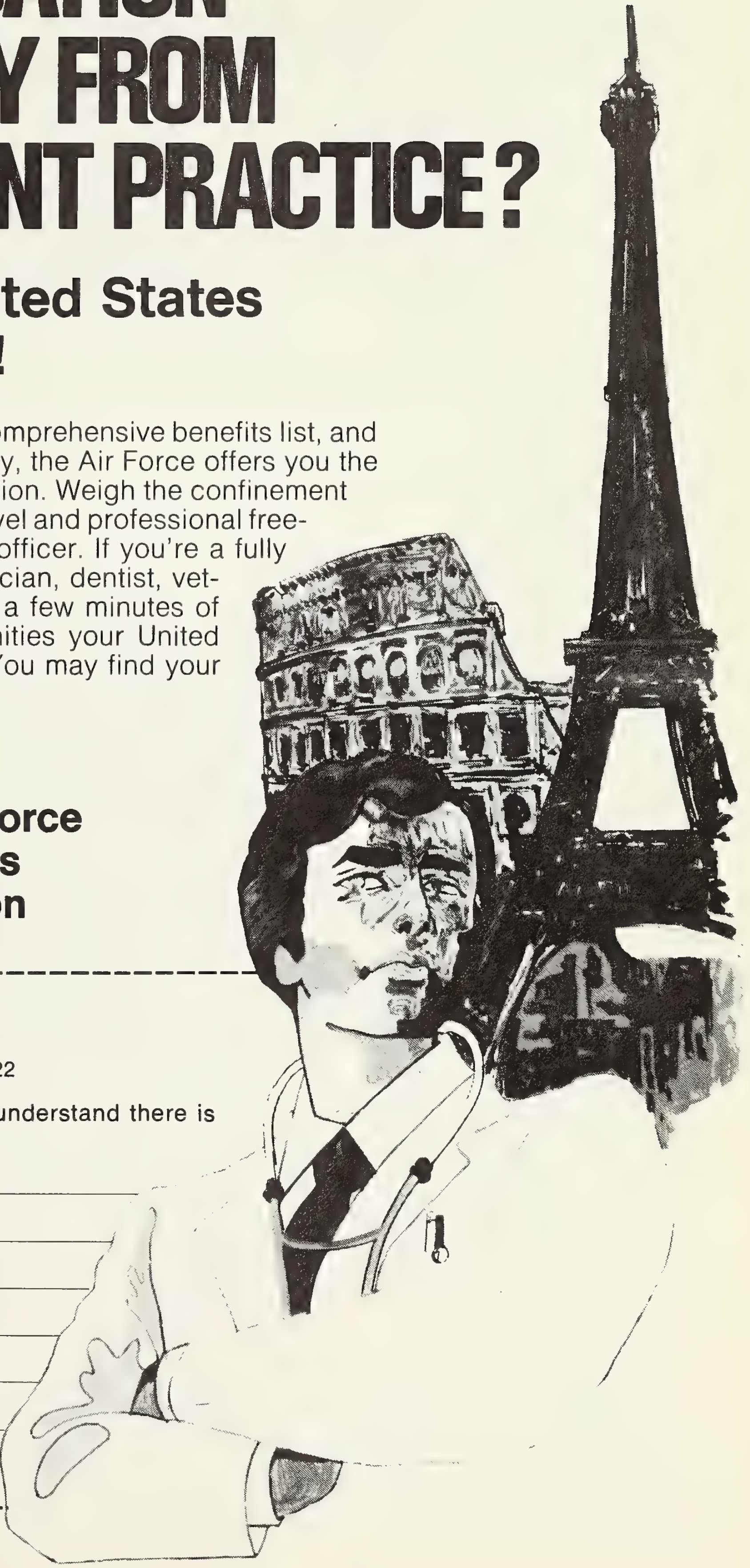

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Air Force Medicine

Letters

"I feel it is important to keep retired MDs in the mainstream . . ."

I would like to express my opinion concerning status and plight of Michigan retired doctors. All physicians hope to be retired some day and steps should be taken to assist them in maintaining their licenses.

In many cases the retired physician uses his license only to do some minor fragmented medical practice, even volunteer, or to be able to write a prescription for a member of his family or friends. Preservation of his license to practice is certainly a small privilege to pay to a doctor who has been a servant of the public for many years. Maintaining of his license preserves his dignity and self-esteem.

Everything is working against the retired physician — even the state medical society and the AMA. I hope I'm not mistaken, but I don't believe there is a retired doctor committee in the MSMS or AMA. If I am wrong, I hope the editor will add a correction. This is why it has become necessary for a new organization, the Retired Physicians Association.

It is an understandable fact that the retired physician should pay the going rate for state and federal narcotics licenses even if he writes only one Rx a year. But the $25 fee for state registration should be reduced for retired physicians who wish to maintain their licenses.

There seems to be no plan to provide retired doctors with malpractice insurance. Apparently a retired doctor would have to buy a $1,000 bond in the MPMLC plan for the privilege of paying a relatively exorbitant fee for malpractice coverage. Therefore it is unlikely that any retired physician will have malpractice insurance.

Whoever wrote Public Act 112 requiring 50 hours of training for all licensed physicians couldn't have known that retired physicians exist. It is obviously unfair to require a retired physician to have the same number of training hours as a doctor in full practice. Many, if not most, of the retired doctors never treat a patient. Many retired doctors, although on the roster of their county medical societies, have moved to distant parts or are out of the community several months a year. Why should they be required to take expensive courses, or travel long distances, for the privilege of paying $25 for a license? I understand that some universities are planning to have audio-visual programs with written tests to provide the required 50 hours of training but I have not seen anything on this program in *Michigan Medicine* or JAMA. If such programs exist, I hope the editor will so state.

This letter might be a waste of words. Possibly a survey of Michigan retired doctors would indicate that they do not wish to maintain their licenses. In this case, the state will lose the $25 license fee and narcotics fee of a large number of retired doctors this coming December.

In World War II, the military services "beat the bushes" to persuade retired doctors to return to practice because the younger doctors were called to service. I feel it is important to keep the retired physicians in the main-stream of medical practice not only for their own satisfaction but for the good of the country. And therefore as many obstacles as possible should be removed from them.

I would welcome the opinion of other retirees in this matter.

Sincerely
Richard D. Mudd, MD
Saginaw

(Editor's note; As to the questions Doctor Mudd raises in the above letter, our sources indicate that there are, indeed, no committees in MSMS or AMA to represent retired physicians. Michigan Medicine *did, however, carry a major article in the April issue about the University of Michigan's media library slide and sound continuing education programs. If used properly, they can earn the doctor CME credits.)*

"The cooperation of your organization . . . is greatly appreciated"

I just want to relay to your membership that the MSMS selection of a speaker for the Elizabeth Wheeler Anspach Lecture proved to be a very excellent one. Doctor Carlyon served your organization admirably by delivering a presentation that was par excellence. We were thoroughly delighted with his thoughts on health education and the therapeutic state.

The cooperation of your organization in furthering the education efforts here at Central Michigan University is greatly appreciated.

Charles E. Reed, PhD
Associate Professor
Department of Health Education

(Editor's Note: The MSMS Department of Communications assisted in the arrangements to bring William Carlyon, PhD, Assistant Director of Health Education at the AMA to CMU to give one of the lectures in the series honoring Elizabeth Wheeler Anspach, first health educator at Central Michigan.)

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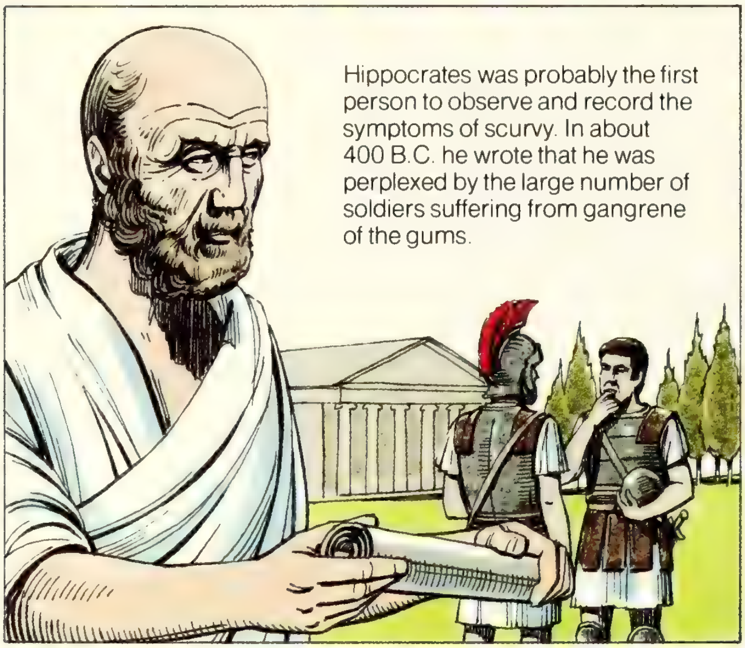
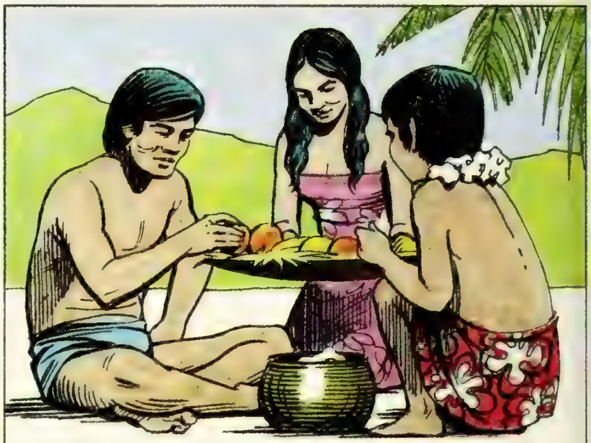
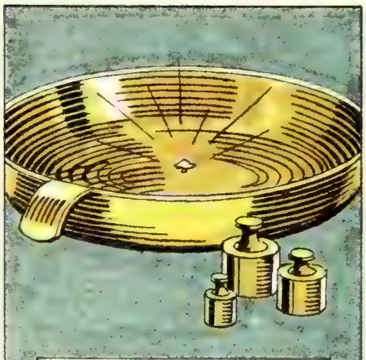


Hippocrates was probably the first person to observe and record the symptoms of scurvy. In about 400 B.C. he wrote that he was perplexed by the large number of soldiers suffering from gangrene of the gums.



People in more primitive, less commercialized societies often eat better balanced diets than affluent Americans. These natives instinctively choose nourishing foods because their bodies tell them what they need. The dietary habits of Americans are often influenced by television commercials that appeal to our wants instead of our needs.



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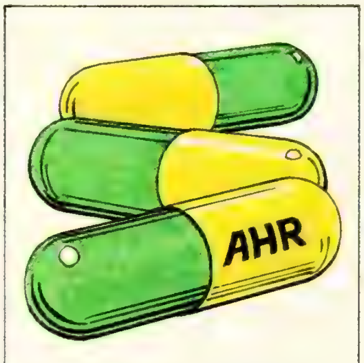

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"I continue to be amazed by the skepticism . . . that insect sting can cause death"

I am deeply concerned about the lack of knowledge of physicians, laymen and paramedics, on all aspects of insect allergy. This lack of knowledge will result in needless deaths. (1) Physicians need to know of the dangers of reactions. (2) Laymen desperately need to recognize the reactions of insects, especially those which forewarn of a possible fatality from a subsequent sting. They need to realize that first-aid medication (i.e., an insect sting kit), as well as hyposensitization, is available and necessary.

Insect allergy has been a very special interest of mine for at least 20 years — especially the clinical aspect of insect allergy. As you know, I have written a book, as well as articles and chapters for medical books. I have lectured to numerous medical associations on this subject. In addition, because of announcements I placed in various medical journals, I have received from physicians scores of case reports of patients who have had reactions to biting and stinging insects, together with the results of hyposensitization, if attempted. In my medical practice, I have seen many insect allergy patients and have received many letters and telephone calls from physicians, asking for my advice on the management of their insect allergy patients.

I continue to be amazed by the skepticism of some physicians that an insect sting can cause death. From personal knowledge, I know that patients who have received fatal stings have often had their symptoms misdiagnosed as being caused by acute myocardial infarction.

In taking the past history of a new patient who comes to me with a chief complaint of asthma, eczema, etc., I frequently find that he has experienced a severe reaction to insects, also. The family history quite often reveals that another member of the family or a relative has also had a severe reaction to an insect. In both instances, they had not been advised to seek further treatment. It had been lightly passed off by the doctor and the patient.

I am appalled when I realize that an insect sting kit in the hands of any person allergic to insect stings could prevent sting-induced death. The time interval between an insect sting and death is around 10 to 20 minutes and usually is not enough time to get to a physician for life-saving treatment. I would like to see our legal statutes changed to allow any layman to purchase the insect sting kit over the counter at any drug store. If this is not feasible at least the kit should be available to emergency personnel — forest rangers, rescue squad personnel, school nurses, etc. Intensive education for the lay public, an absolute necessity, could begin with the use of television and the printed media.

In the last few months I wrote a letter to the editors of medical journals across the United States in which I asked physicians for their opinion on insect sting kits being made available to emergency personnel. State laws may vary but in most states if a child is suffering from a severe reaction as a result of an insect sting it is illegal for a school nurse to give him an injection of epinephrine to save his life. (*Michigan Medicine* may want to take some action to support the changing of this law.) I received many replies from physicians who wholeheartedly agreed that these people should have an insect sting kit on hand. To my dismay, without exception, *no physician* who replied knew of such a kit, its contents, and indications for use. The concern and interest is there. The knowledge is not. Pharmacists, the Department of the Army, and the Public Health Service were among some of the large groups represented in the replies.

The letter bears out my urgent request for a concentrated world-wide education. Editorials and articles in all the medical journals (most all physicians see this type of patient), simply giving the symptoms or reactions, treatment by the physician, and proper medication for the patient to have on hand in case of another sting. Information about the insect sting kit, a Medic-Alert emblem, and possibly about hyposensitization to these insects should also be included. Symposia and lectures at the local, state and national medical meetings would be of great benefit to physicians and knowledgeable physicians could be stimulated to educate the layman through the local and national media.

Much more needs to be done now and it must be an all-out effort by the Michigan State Medical Society. I believe an editorial on the subject in the *Michigan Medicine* would be of great benefit. At any rate, we must all back this with a conscientious effort to disseminate this knowledge to all. Otherwise, I fear it will be as before. Any half-hearted effort will not succeed.

I am sending this material to you to emphasize the importance of educating the physician as well as the public. We have delayed too long.

Sincerely,
Claude A. Frazier, MD
Asheville, NC

"Health care" vs. "illness treatment"

"I believe you could provide a useful educational service by refraining from the use of 'health care' as the phrase describing the objective for the use of monies collected by most insurance companies.

"These monies pay for illness treatment and are rather strictly limited to use for illness detection, if the person does not have some already observable symptoms. I am aware of very little money allocated to the promotion of health, and I urge your correction of this significant error in labeling.

"I am not able to detect strong emphasis in the development of a system which provides health enhancement opportunities. Illness treatment, requiring the development of the illness prior to the institution of service, accounts for the major share of money directed for medical purposes."

JAMES TERRIAN, MD
Director, Eastern Upper Peninsula
Health Departments
Newberry

(Note: This "letter to the editor" appeared in the Detroit Free Press after the paper carried an editorial on "health care.")

Michigan gains MDs; fewer practice in offices

Michigan gained 236 doctors of medicine during the past year, according to the Michigan Health Council and the Michigan Department of Licensing and Regulation.

One of the prime reasons for the increase in medical doctors is the number of young medical doctors entering graduate medical training in Michigan teaching hospitals, according to John A. Doherty, executive director of the Health Council.

"This year we have 750 new interns and 1,970 new residents in training, compared to 460 and 1,679 in 1974-75," he writes in a recent Health Council publication, "Health Manpower for Michigan."

The Health Council, which maintains a physician placement service for Michigan, reports that 42 counties gained medical doctors, while 19 lost numbers of MDs. Wayne County

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had the greatest gain, with 85 more MDs, followed by Macomb with 36; Oakland, 34; Saginaw, 24; Ingham, 20; Kalamazoo, 15; Genesee, 14; Midland, 10; Marquette, 6, and Houghton, 4.

But, according to the AMA Department of Survey Research, Mr. Doherty reports, Michigan lost 62 family doctors and 144 MDs in office-based practices.

These losses, as well as a net loss of 14 osteopathic physicians, he attributes to the high cost of professional liability insurance, as well as new legislation and high taxes affecting Michigan physicians.

"The Michigan Health Council is especially appreciative of the efforts of the MSMS and Michigan Hospital Association in setting up liability companies for their members," Mr. Doherty writes. "Hopefully, this will substantially reduce the cost of coverage and make it feasible to attract new doctors, as well as keep more family and office-based physicians."

There is a need yet for 1,776 more physicians in more than 125 Michigan communities, he reports.

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

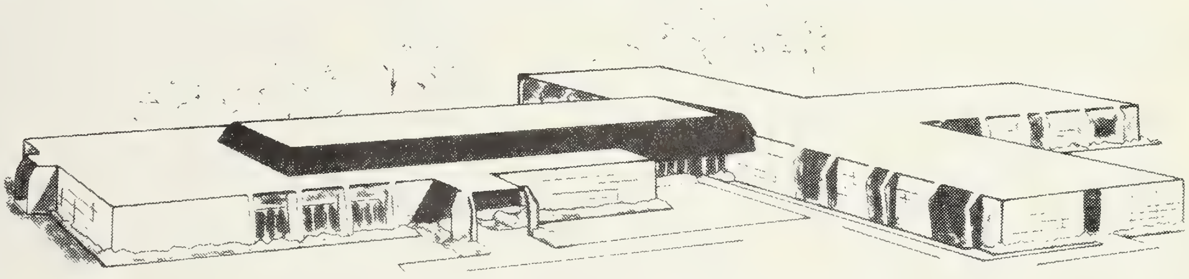
For the Five-week Period Ending April 2, 1976

	1976 This 5-Week Period	1975 Same 5-Week Period	1976 Total To Above Date	1975 Total Same Date	Total Cases for 1975
Rubella	305	316	554	568	1,975
Cong. Rubella Syndrome	0	1	0	1	1
Measles	1,084	716	1,395	1,159	3,253
Whooping Cough	5	3	25	26	98
Diphtheria	0	0	0	1	1
Mumps	1,367	1,736	2,753	4,042	9,979
Scarlet Fever & Strep Sore Throat	3,602	3,480	8,417	8,647	23,777
Tetanus	0	0	0	0	0
Poliomyelitis (paralytic)	0	0	0	0	0
Hepatitis	243	278	624	761	2,877
Salmonellosis (other than S. typhi)	75	82	200	225	864
Typhoid Fever (S. typhi)	1	0	1	1	10
Shigellosis	43	74	122	220	745
Aseptic Meningitis	8	7	25	21	280
Encephalitis	9	8	24	18	168
Meningococcic Meningitis	15	14	27	32	76
H. Influenza Meningitis	16	12	36	33	142
Tuberculosis	143	102	326	335	1,220
Syphilis	110	173	298	418	1,614
Gonorrhea	3,029	3,059	8,024	7,728	32,472

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

FOREST VIEW PSYCHIATRIC HOSPITAL



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Heartbeat

William L. Knapp, MD, Detroit, is new president of the Detroit Industrial Physicians Club. William Jend, MD, is president elect.

* * *

Nicholas Lentini, MD, Cheboygan, was honored by his city when the mayor proclaimed March as "Doctor Nicholas Lentini Month." A physician and surgeon in Cheboygan since 1941, Doctor Lentini's lifetime of achievements and service to his fellow man were recounted in the long proclamation and perhaps summed up best in the last whereas: "His willingness to serve his fellowman, his total dedication toward eradicating illness and his compassionate response to relieving pain and suffering, does indeed illustrate that Doctor Nicholas Lentini is a physician who is totally committed to the meaning of the Hippocratic Oath . . ."

* * *

Robert W. Oakes, MD, Harbor Beach, president of the Michigan Academy of Family Physicians, was recently honored by a Concurrent House-Senate Resolution saluting him as MAFP president. Most importantly, the resolution cites him and the MAFP for their "decisive role in the effort to secure more family physicians for the people of Michigan."

* * *

Richard Philleo, former MSMS legislative representative, recently resigned as executive vice president of the Michigan Association of Realtors. He and Mrs. Philleo are moving to Kona in Hawaii.

H. Marvin Pollard, MD, Ann Arbor, U-M professor of internal Medicine, is due to receive the American Society of Gastrointestinal Endoscopy's Rudolph Schindler Award in May. The award is given annually to persons who have made outstanding contributions in the field. A U-M research team headed by Doctor Pollard invented the first fiberoptic gastroscope in 1956. It became the prototype of current such diagnostic instruments.

* * *

Joseph L. Posch, MD, Detroit, and associates, are authors of three scientific papers published recently. The Journal of Bone and Joint Surgery published "Ulnar Variance in Kienbock's Disease" in July, 1975, and "High-Pressure Injection Injuries of the Hand" in October, 1975. "Surgical Treatment of the Carpal Tunnel Syndrome" was printed in the German Publication, "Handchirurgie."

* * *

Kenneth J. Ray, MD, Grosse Ile, has been recommended for appointment to the National Professional Standards Review Council. Dr. Ray is currently chairman of the MSMS Committee on Professional Standards Review Organizations.

* * *

Daniel Reardon, MD, Grand Rapids, director, pediatric residency training program at Butterworth Hospital and Blodgett Memorial Medical Center since 1973, was presented a special award in Mid-March from the Western Michigan Chapter of the National Association of Social Workers. Doctor Reardon was recognized for his "unselfish time in examining abused and neglected children, testifying in court on child abuse and for his efforts toward assuring proper care of children."

Werner U. Spitz, MD, Detroit, Chief Medical Examiner of Wayne County, was visiting professor, Department of Pathology, University of New Mexico School of Medicine, April 19-24.

* * *

Lee B. Stevenson, MD, Detroit, is new moderator of the Council of Specialty Societies, succeeding Arthur J. Johnson, MD, Detroit. CSS vice moderator is Glenn E. Moore, MD, Flint, former moderator.

* * *

Bernard Veenstra, MD, Grand Haven, Christian Helmus, MD, Philip H. Dommisse, MD, and Lewis J. DeKryger, MD, all of Grand Rapids, are among U.S. physicians who have spent time in earthquake-ravaged Guatemala since the devastation in early February. Area newspapers have carried detailed accounts of their visits, work and activities. Several had previous connections with the area through missionary assignments served in Central America.

* * *

William B. Weil, MD, East Lansing, is recipient of a distinguished faculty award from Michigan State University, for his activities in establishing professional liaison between the MSU College of Human Medicine and pediatricians in medical school-affiliated communities. Doctor Weil is chairman, MSU Department of Human Development, College of Human Medicine.

LEGISLATION

The threat of inadequate funds overshadows all capitol news

By Bruce Ambrose, Manager
MSMS Department of Government Relations

The Legislature returned from its traditional Easter recess April 26 to a workload dominated by continuing state fiscal emergencies. Over all other matters lies the threat of inadequate state income — or excess state commitments — and how to face the problem.

Thus the appropriation to the Department of Social Services, including Medicaid allocations, over-shadows health and medical interests in the 1976 session of the Legislature.

Medicaid reimbursement

With an 11 per cent discounting of Medicaid bills in effect since January, and severe withholdings of payments to hospitals, appropriators are searching for corrective means. The Governor's executive budget proposes a $27.6-million increase in physicians' services allocation, which would restore the 11 per cent now being discounted but would retain unchanged screens for Medicaid services.

With the DSS appropriation remaining under scrutiny, some lesser appropriations are being reported, with a slight general trend to exceed the executive recommendations.

Status of Key Bills

Meanwhile, other legislation items are beginning to increase in intensity.

House Bill 4804 has cleared committee work in the Senate and was on the Senate floor when the Legislature recessed. The bill would require review of every physician's file annually before re-registration is permitted, add two public members to the **Medical Practice Board,** establish subboards to hear complaints against physicians, and attempt to establish a formula by which re-registration fees can be raised as the Medical Practice Board receives additional allocations. Effective date of the bill is tied to the next effective appropriations date to the Department of Licensing and Regulation. The bill faces House concurrence before going to the Governor for veto or signature.

Most interest in health and medical legislation upon the return of the Legislature seems to rest on the report of the **Public Health Statutes Revision Project.** The document sent to the Legislative Service Bureau for writing into legislative language proposes extensive rewriting of public health statutes into a single code.

An ad hoc committee of the Michigan State Medical Society, chaired by James A. Read, MD, Birmingham, has monitored the project throughout the development of the code, and submitted an analysis of the project report endorsing it with specific exceptions.

MSMS objections are 1) the Health Occupations Article which would expand the authority of the Department of Licensing and Regulations and establish a concept of licensure by specialty; 2) an expanded Certificate of Need; 3) changes in qualifications for the director, Department of Public Health, no longer requiring a physician director; and 4) alterations in laboratory licensure.

Other bills of major significance in the 1976 Legislature are:

HB 5325, to permit pharmacists to **substitute generic drugs** without informing the purchaser. MSMS opposes the bill, as now written, which has passed the House of Representatives and is before the Senate Committee on State Affairs. MSMS is arguing that the customer must be informed when a substitution occurs, and is seeking an amendment to that effect.

HB 5945, to rewrite the **chiropractic** practice act permitting a broad scope of practice by chiropractors. MSMS opposes the bill on grounds that it would allow untrained persons to practice medicine in Michigan. The bill is before the House Committee on State Affairs.

House Bills 6079, 6080 and 6081, a series of bills to regulate and establish **physician's assistants** in Michigan. The bills would create a "committee" on registration of physician's assistants. The committee would be composed of members of the Medical Practice Board, Osteopathic Practice Board, physician's assistants and the public. The Medical Practice Act and Osteopathic Practice Act would be amended to give final accountability for physicians who use physician's assistants to the appropriate practice board. MSMS supports the bills, which now are before the House Committee on State Affairs.

Earlier in the year the Medical Society was instrumental in deleting **nuclear medicine** from a proposed regulation of transportation of radioactive waste materials. Two bills are designed to govern such movement of radioactive waste, and originally proposed to include nuclear medicine. As rewritten and presented to the House Public Health Committee, nuclear medicine has been deleted from regulations.

Four proposals to systematize **emergency health care delivery** in Michigan have passed the Senate and been reported favorably to the full House. The bills — Senate Bills 984, 985, 986 and 987 — include licensure for ambulances, categorization of hospital emergency services, planning and use of personnel. The package carries a cost estimate of $167,000, which has been recommended by the Governor, and the bills have been referred to the House Appropriations Committee for further review.

1976 Auxiliary Legislative Day

Michigan physicians' spouses met recently in Lansing for their annual session on becoming more politically effective. The Legislative Day, arranged by Auxiliary legislative chairman Norma Westerhoff of Grand Rapids, featured talks by Vernon V. Bass, MD, president, Michigan Physicians Mutual Liability Company; Brock E. Brush, MD, MSMS president; Bruce Ambrose and Warren Tryloff of the MSMS staff, Mrs. Robert C. Prophater. Many Michigan legislators joined the auxilians for lunch. Scenes from the Legislative Day appear on this page.

Mrs. Westerhoff

Dr. Bass

From left, Mrs. S. A. Yannitelli, '75-'76 Auxiliary president; Mrs. William Dixon, '76-'77 Auxiliary president; State Supreme Court Justice Lawrence B. Lindemer, and Doctor Bass.

The intricacies of the new arbitration system for settling arbitration disputes in medical malpractice cases is described to Auxiliary members by Rhoda M. Powsner, MD, right, member, Arbitration Advisory Committee to the state insurance commissioner.

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Medical Practice Board

By Sherry Wellman, MSMS Liaison with Governmental Agencies

Meeting of March 3

The Michigan Medical Practice Board:

1. Considered a request from the Michigan Department of Public Health, the University of Michigan School of Public Health and the Michigan Health Officers Association to form a coalition offering continuing medical education programs for public health officials. The board gave the coalition tentative approval pending accredition by the MSMS Commission on Continuing Medical Education.

2. Discussed the board's withdrawal from consideration by the Joint Administrative Rules Committee of the Legislature of administrative rules governing procedures for contested cases. Contested issues are the board's authority to delegate certain functions to its administrative staff and the board's authority to issue summary suspensions. Board representatives will meet with key legislators and the attorney general's deputy to resolve the matter.

3. Endorsed legislation governing physicians' assistants and related amendments to the Medical Practice Act. Board members Doctor Kuiper and Doctor Moses have been actively involved in drafting legislation and believe it represents a realistic way to regulate utilization of physicians' assistants. The MSMS Committee on State Legislation and Regulation previously supported the decision of the board regarding the legislation.

4. Gave formal approval to an agreement between the board and Steven G. Tarangle, MD, regarding his licensure status. Doctor Tarangle was placed on probation for a period of two years for failure to disclose prior disciplinary proceedings in California and the Province of Alberta when application was made for Michigan licensure in 1973.

5. Reviewed a letter from the Michigan Academy of Physical Medicine and Rehabilitation regarding electromyographic examinations by technicians. The academy urged the board to reconsider its ruling of June 1975 that "Interpretation of an EMG must be done by a physician, but that the performance of an EMG may be delegated by the physician to a trained technician. This would apply only where permanent records are kept on EMGs. Diagnosis or treatment based on this information must be done by a licensed physician." The academy position that EMGs should only be performed by a licensed physician was supported by Resolution 72S-9 adopted by the Michigan State Medical Society. The Board decided not to change its present policy pending further information from the American Board of Neurosurgeons and the Board of Neurology.

6. Appointed board member Doctor Moses to chair a subcommittee to develope guidelines and procedures for the board in evaluating candidates for Michigan licensure who have not had AMA-approved internships or residencies in the United States.

7. Denied application for Michigan licensure by endorsement of Pennsylvania for Doo Sik Shin, MD. The basis for the decision was that the exam given in Pennsylvania in 1971 was not substantially equivalent to the FLEX exam administered by Michigan in that same year and that when Doctor Shin took the FLEX exam in December of 1974 he failed to attain a weighted average of 75% as required.

8. Issued a limited license to Edward W. Walters, MD, restricting his practice to the Physicians Community Clinic, PC, in Detroit.

9. Objected strongly to proposed guidelines being developed by the Federal Equal Employment Opportunities Coordinating Council which would declare any licensing examination (FLEX) discriminatory on its face should any minority group have a failure rate substantially different from the norm group. The board agreed with the position of the Federation of State Medical Boards that such a policy would place in jeopardy the entire issue of licensure by examination. The board also moved that an appropriate resolution be introduced to the AMA and MSMS Houses of Delegates.

10. Heard a report by member John Wilson, MD, on the activities of the Investigation Committee regarding status of complaints, determination of sufficient evidence to initiate an investigation and progress on the establishment of the Medical Science Unit. Doctor Wilson also recommended that additional priority items for board consideration should be advertising, chiropractic and acupuncture investigation.

11. Instructed the executive director to respond to an inquiry that it was the consensus of the Board that the installation and/or operation of a computerized sphygmomanometer does not represent a violation of the Medical Practice Act. The instrument measures a person's blood pressure.

Meeting of April 1, 1976

The Michigan Medical Practice Board:

1. Noted with regret the resignation of Robert C. Prophater, MD, from the Medical Practice Board.

2. Heard a verbal report from John W. Moses, MD, member of the Board, on guidelines and procedures for evaluating candidates for Michigan licensure who have not had AMA-approved internship/residency training in the U.S. Doctor Moses was requested to put the recommendations into written form for the Board's official consideration at the next meeting.

3. Gave consideration to the fact that of the 1,000-plus applications to take the June FLEX examination, over one-half are from other states. The main reason for the popularity of the Michigan exam is the few restrictions placed on applicants. Ohio, for example, requires applicants to submit a letter of intent to practice in that state and Illinois requires completion of two years' postgraduate education before taking the exam. Given the expense of administering the large number of exams, and compared to the small percentage of examinees who stay in Michigan, the Board will consider alternatives to meet the problem.

4. Reviewed the status of current investigations and disciplinary proceedings.

5. Received a report on the legislative status of the physicians' assistants proposal, specifically the objections raised by optometry, podiatry, pharmacy and nursing. The bill is pending in the House Committee on State Affairs.

6. Discussed the budgetary process and lack of opportunity for Board input with representatives of the Department of Licensing and Regulation. The Department agreed to give the Board increased opportunity to submit recommendations and to include members of the Board in financial decisions affecting Board activities.

7. Review a suit filed by the Michigan State Chiropractic Association against Michigan Attorney General Frank Kelley because of the number of civil suits the AG has brought against chiropractors, charging them with practicing medicine without a license. The Board also reviewed an opinion by the Attorney General to the effect that using hypnosis to treat human illness constitutes the practice of medicine. The opinion stated that a medical license is not required to use hypnosis if the practitioner falls into one of several exclusions in the medical practice act or if the person is licensed under other laws as long as his activity falls within the limits of that license.

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Prehlad S. Vachher, M.D.
Richard D. Watkins, M.D.
Robert M. Zimmerman, M.D.

Wayne County Medical Society staging new member receptions

The **Wayne County Medical Society** is instituting a program to acquaint new members with the organization. The WCMS Council recently adopted a recommendation of the Membership Committee to hold two informal "new member receptions" per year. Officers of the WCMS, membership committee members, MSMS representatives and others will be on hand to welcome the new members and their spouses and acquaint them with the medical society's activities.

On April 5, Wayne County Medical Society members heard a presentation on "Two Centuries of American Medicine" from Dwight E. Harken, MD, professor of surgery emeritus, Harvard University, who presented the 55th Annual Beaumont Lecture. The series commemorates the work and contributions of pioneer doctor and surgeon William Beaumont whose work contributed so much to the understanding of the human digestive system.

* * *

The Kent County Medical Society's Kent Medical Foundation maintains a tuition grant program for the four local colleges and three hospital schools of nursing in Grand Rapids. It also makes loans to medical students. To date, the Foundation has awarded 329 tuition grants totaling $109,335 to 270 deserving students. In addition, it has made loans totaling $101,092 to 59 medical students, for an overall assistance total of $210,427. The Foundation depends on voluntary contributions and memorials to carry on its programs.

Muskegon County Medical Society members recently invited Kathryn Richards, MD, Ann Arbor burn surgeon, to give a presentation on burn treatment. With the aid of slides she discussed the treatment of a person with burns over 85% of the body. Fluid therapy and the do's and don'ts of burn treatment were included. George Bruinsma, Muskegon Heights fireman representing a local organization known as "Bucks for Burns," presented Doctor Richards with a $2,500 check for the Ann Arbor Burn Center of which Doctor Richards is the associate director.

Last month, Michigan Secretary of State Richard Austin spoke to the MCMS on "Physician's Examination of the Hazardous Driver." At the May meeting, the MCMS will honor all 28 of its living past presidents at a special dinner.

* * *

Judith W. Krupka, PhD, associate dean, Office of Student Affairs, Michigan State University College of Human Medicine, recently told the **Kent County Medical Society** "How To Get Your Kid Into Medical School." She outlined a crisis in medical school admissions, pointing out that it is highly likely that an applicant will be extremely qualified and still be unable to obtain a place in a U.S. medical school. She noted there are 600 places for some 1,700 applicants in Michigan. Doctor Krupka emphasized the need for preparing students for the fact that they may not get into medical school despite their excellent qualifications.

Students honor MSU medical faculty

Graduating medical students at Michigan State University's College of Human Medicine have honored five voluntary clinical faculty members for their "dedication, interest and abilities in the art of teaching."

The five practicing physicians received certificates of achievement for outstanding teaching in MSU community programs. The awards were made at the medical school's commencement convocation held in March in East Lansing.

Award recipients are: J. Bernard Sloan, MD, Flint urologist; John R. Horn, MD, Grand Rapids internist; Robert D. Brouwer, MD, Kalamazoo gastroenterologist; Lakshmipathi Rao Kareti, MBBS, Lansing surgeon, and Chaiyakarn Soontharotoke, MD, Saginaw pediatrician.

John Jones, MD, MSU professor of internal medicine, received a certificate of achievement for the "best teaching during the first two years of the MD program by a fulltime faculty member."

Dan C. English, MD, chief of the MSU division of general surgery, received a certificate of achievement for the "best teaching by a fulltime clinical faculty member, on or off the East Lansing campus."

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Challenging opportunities in clinical research for physicians interested in the development of new immunosuppressive agents and drugs for treatment of allergic and non-allergic respiratory diseases. Responsibilities include collaboration and selection of candidate drugs for clinical evaluation and design, supervision and interpretation of clinical studies required to determine drug safety and effectiveness. Current projects include testing of antithymocyte globulin as an immunosuppressant and evaluation of prostaglandins and other agents in Type 1 allergy. You should be qualified in internal medicine, pediatrics or clinical pharmacology. Training or interest in pulmonary diseases or clinical immunology desirable.

DIABETES & ATHEROSCLEROSIS RESEARCH

Physician needed to develop and conduct clinical trials for the development of drugs in the areas of atherosclerosis, diabetes and/or thrombosis. Other responsibilities include providing original medical expertise as part of a team research effort geared toward finding product candidates in the above areas, participating in diabetes and atherosclerosis clinics and conducting clinical research on the basic disease processes of atherosclerosis, diabetes and thrombosis.

Qualifications: besides M.D., Board Elig. or Cert. in internal medicine or pediatrics; experience in clinical practice; ability to organize and complete clinical studies within gov't. regulatory controls; and, experience with metabolic or endocrine problems desirable.

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In Memoriam

Kent A. Alcorn, MD
Bay City

Marshall W. Alcorn, MD
Bay City

Long-time Bay City urologists Kent A. Alcorn, MD, and Marshall W. Alcorn, MD, brothers, died within a month of each other on March 24 and Feb. 28, respectively. Doctor Marshall Alcorn was 71 and Doctor Kent Alcorn was 77.

Both were graduates of the University of Illinois Medical School. Doctor Kent Alcorn had served as chief of staff at Bay City Mercy Hospital and chief of surgery at Mercy and Bay City General Hospitals. Doctor Marshall Alcorn was chief of staff of Bay City General Hospital. Both were members of the North Central Branch, American Urological Association, and fellows of the American College of Surgeons.

Marian I. Chaskes, MD
Haslett

Lansing-area psychiatrist Marian Iddings Chaskes, MD, died March 16 at the age of 58. Doctor Chaskes was affiliated with E. W. Sparrow and St. Lawrence hospitals in Lansing and belonged to the Michigan Psychiatric Society and American Psychiatric Association. She had been a member of the local mental health board and community nursing bureau. She was a graduate of the University of Michigan Medical School.

Samuel Eder, MD
Detroit

Retired Detroit family physician Samuel J. Eder, MD, died March 2 at the age of 84. Doctor Eder had practiced in Detroit for 50 years and was graduated in 1914 from the Wayne State University School of Medicine. He was active in community affairs.

Marinus H. Hamelink, MD
Grand Haven

Long-time Holland family physician Marinus H. Hamelink, MD, died March 20 at the age of 74. He was former chief of staff at Holland Hospital and was a graduate of the University of Michigan Medical School.

John R. Heindenreich, MD
Daggett

John R. Heidenreich, MD, Daggett, MSMS alternate delegate to the AMA for many years and active MSMS committee member, died March 6 at the age of 69. He was a family physician and community leader in Daggett for nearly 40 years and helped build its medical facility. Doctor Daggett was a member of the North Central Branch, American Urological Association and the Upper Peninsula Medical Society. He was past president of the Menominee County Medical Society and was a graduate of the University of Minnesota Medical School.

Lawrence E. Henrich, MD
Clearwater, Fla.

A 50-year member of the Providence Hospital staff, former Detroit family physician Lawrence Edmund Henrich, MD, died March 14 at the age of 78. He had resided in Clearwater, Fla. since his retirement in 1970. Doctor Henrich was a graduate of St. Louis University Medical School.

Irvin J. Kurtz, MD
Southfield

Irvin J. Kurtz, MD, past president of the Michigan Board of Registration in Medicine, died March 15 at the age of 65. Doctor Kurtz was a general surgeon and a graduate of Wayne State University School of Medicine. He was chief of staff at Redford Community Hospital and was affiliated with The Grace Hospital. He was a fellow of the American College of Surgeons.

Ralph W. Lenz, MD
Coldwater

Coldwater internist Ralph W. Lenz, MD, died March 24 at the age of 47. He was a graduate of the University of Michigan Medical School and a native of Montana. He was affiliated with the Branch County Community Health Center.

John A. Maloney, MD
Southfield

Grace Hospital staff physician for 50 years, John A. Maloney, MD, died March 18 at the age of 81. He was a graduate of the Detroit College of Medicine, had served as physician for Southfield police and fire departments and as township coroner.

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"Physician's Damage Suit for Loss of Staff Priveleges Filed Too Late"
Michigan Court of Appeals, July 22, 1975
from *The Citation,* Vol. 32, No. 7

"No Fraudulent Concealment of Physician's Name in Suite"
Michigan Court of Appeals, Aug. 14, 1975
from *The Citation,* Vol. 32, No. 9

"Physician's Employees May Refuse to Attend Meetings on Day Off"
Michigan Court of Appeals, Aug. 12, 1975
from *The Citation,* Vol. 32, No. 7

"Damages Denied for Birth of Child After Tubal Ligation"
Michigan Court of Appeals, June 9, 1975
from *The Citation,* Vol. 32, No. 6

$750,000 for Child's Death After Delivery in Emergency Care"
Michigan Circuit Court, 1976
from *The Citation,* Vol. 32, No. 4
Dec. 1, 1975

"Dentist not Liable in Suit for Invading Sinus Cavity"
Michigan Court of Appeals, Aug. 12, 1974
from *The Citation,* Vol. 32, No. 4
Dec, 1, 1975

"Pill Manufacturer Not Liable For Death of Patient"
District Court, Michigan, June 11, 1975
from *The Citation,* Vol. 32, No. 5

Medical Students May Not Prescribe Controlled Drugs

Medical students, while performing the duties assigned to them in the course of training, may draft an order for a drug for the approval and authorization of a licensed practitioner.

However, before that order becomes a valid prescription that can be filled by a pharmacist, a licensed practitioner must complete the order in the manner required by the Controlled Substances Act.

That is the opinion of Michigan Attorney General Frank J. Kelley on the question of whether medical students may prescribe controlled substances and prescription drugs under the exemptions applied to them by the Medical Practices Act "while performing the duties assigned to them in the course of training."

Kelley noted that this opinion does not apply to interns and residents, but only to those students not licensed yet to practice medicine.

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NEED: Internist or Generalist at the Traverse City Office of the Disability Determination Program. Full time; good fringe benefits; competitive salary; ideal 4 season living area; and equal opportunity employer. No malpractice insurance required. Call: (517) 373-7789 (collect) OR Write: Michigan Dept. of Education, Vocational Rehabilitation Services, Disability Determination Program, Box 1200, Lansing, Michigan 48904, Att: David P. Gage, M.D., Chief Medical Consultant.

GP FP needed to associate with three GP MD's covering area of 150,000 people, three open hospitals with ICU, CCU and emergency room coverage. Liberal salary with incentive bonus. Pension and profit sharing plan. Rotate nights and weekends. Response to J. R. Young, M.D., 719 Capital Avenue, S.W., Battle Creek, Michigan 49015.

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I am board-certified in Internal Medicine and will finish two years of a university Cardiology fellowship in July 1977. My interest is in the practice of clinical Cardiology (including non-invasive procedures) and Internal Medicine. My family and I are now in another state but we would like to settle in our home state — Michigan. We will be visiting Michigan in Mid-May. I may be contacted via the following address/phone: Interested Cardiologist-Internist, 15717 Rosemont, Detroit, Michigan 48223 or (404) 296-8259.

PHYSICIAN'S ASSISTANT: available June 1976. 32 year old, ex-Navy Corpsman, BS Purdue 1974, BS Physician's Assistant Program, College of Medicine, University of Iowa, 1976. Seeking rural FP or Peds setting. Resume on request. J. David Girard, RR #5, Box 213, Rensselaer, Indiana 47978.

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BOARD ELIGIBLE. Pediatrician and Nuclear medicine, completing nuclear medicine residency June 30, 1976. Seeking position as of July 1976. Reply Box #6, 120 W. Saginaw St., East Lansing, Michigan 48823.

INTERNIST, Primary physician, desires position. Experience in Emergency Medicine, Administration, Industrial Medicine, Institutional Medicine and Civil Service. Will accept position requiring travelling. Reply Box #7, 120 W. Saginaw Street, East Lansing, Michigan 48823.

EAST LANSING — (Ingham County — S.W.) — MICHIGAN STATE UNIVERSITY is currently recruiting for staff physicians. One of the 10 largest universities in the Nation with an enrollment of over 40,000. Located in a metropolitan area of 250,000. the OLIN MEMORIAL HEALTH CENTER, located on the campus, provides facilities for students in need of medical, acute surgical or psychiatric care. It is a well-equipped general hospital with a large outpatient section. Position would be full time with 30-day paid vacation. Physicians must be licensed to practice in Michigan or immediately capable of obtaining such license. Facilities include a completely outfitted office suite; no other equipment needed. Professional work is essentially in the category of general practice with surgery confined to the limits of the individual's experience. No pediatric, geriatric or obstetrical services provided. Staff physicians rotate on night calls and weekends. Fringe benefits include Social Security, term life insurance, malpractice insurance, excellent retirement program, hospitalization and medical insurance, and staff privileges for University cultural program and intercollegiate athletic events. Minimum starting salary $30,000 annually. Contact: Administrator, Health Center, Michigan State University, East Lansing, Mi. 48824, (517) 355-4510.

PHYSICIANS: interested in regular hours, liberal salary and fringe benefits. Stimulating medical careers in emergency and critical care medicine. Send resume to: Wayne M. Bailey, Administrative Director, Critical Care, 724 South Edisto Avenue, Columbia, SC 29205.

OB-GYN, Internist, Family Practitioners wanted to join an expanding multispecialty group in Southwestern Michigan. Clinic located next to 89 bed general hospital, with excellent staff and equipment, to provide high quality medical care. All members of group are board certified or eligible. Excellent fringe benefits and starting salary. Write or Call: Gary Piippo, Administrator, Allegan Medical Clinic, PC, 551 Linn Street, Allegan, Michigan 49010. Phone (616) 673-8402.

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POTPOURRI

By Herbert A. Auer, Executive Editor

"All action programs go through three periods," Pauline Carlyon, Chicago health educator, told a MSMS task force. The steps she suggested are (1) Identification of a problem, (2) Period of apathy because problem seems so big, and (3) Movement and action are likely and possible then if there is consistent leadership and interest.

* * *

"Of course we all belong to our county and state medical societies, and to the American Medical Association. These are things which are expected of every active and ethical physician. If we are not getting anything, or very little, out of our medical societies, the reason is not far to seek: it is because we are putting nothing into them. You can't get anything out of a jug (or a medical society) that hasn't first had something put into it." (This appeared in July, 1925 issue of MSMS Journal as an unsigned editorial.)

* * *

The University of Michigan Medical School has been listed among the top ten in the nation by *Medical Economics*. The U-M placed second in the number of schools producing board certified specialists, was among the top ten in producing medical school faculties; and among the top eleven in producing deans for other medical schools.

"Crisis in Parenting," a problem that personally concerns physicians, is being tackled in Michigan and the nation by the national PTA and March of Dimes. Today, one of every six children lives in a divorced or single parent household.

* * *

Bicentennial slogan for the month: "America is your past; you are her future."

* * *

"One of our major goals," declares Edward Conner, MD, president of the Lenawee County Medical Society, "should be to help the public to understand the patient's role in his own care." Doctor Conner's message was one of the features in the LCMS News which recently was reinstituted by Richard Coak, MD, editor.

* * *

If your thesaurus is well-thumbed, you will find the new *Reverse Dictionary* fun to use. It's published by Quadrangle/New York Times Book Company, Dept. 888, 10 E. 53rd St., New York, NY 10022.

* * *

The publication of the American Society of Internal Medicine began a three-part series in the February issue of "The Internist" about "Curing and Caring in Perspective." The February article closed, "All we need to do is to combine science and art into a unified whole."

Recently I heard two very good speakers who had chosen words beginning with "P" in order to punch home their message. One speaker urged organizations and leaders (1) To Program, (2) To Proclaim, and (3) To Profess. And then several days later the second speaker talked about the importance of (1) Principle and (2) Program. I was interested to hear this man challenge church leaders to never forget the importance of (3) "Parking."

And all of these suggestions relate to medical organizational goals and programs, right?

* * *

In the next 10 years, there will be a ten percent drop in those people under 15; four percent in 15-24 category; thirty-three percent increase in 25-44 category and nineteen percent in the over-65 group. These figures are from a Gilbert Youth Research study.

* * *

A national medical journal reports that insurance companies in California during a one-year period, 1974-75, paid $23 million for settlement of nuisance claims and $7 million for bonafide claims.

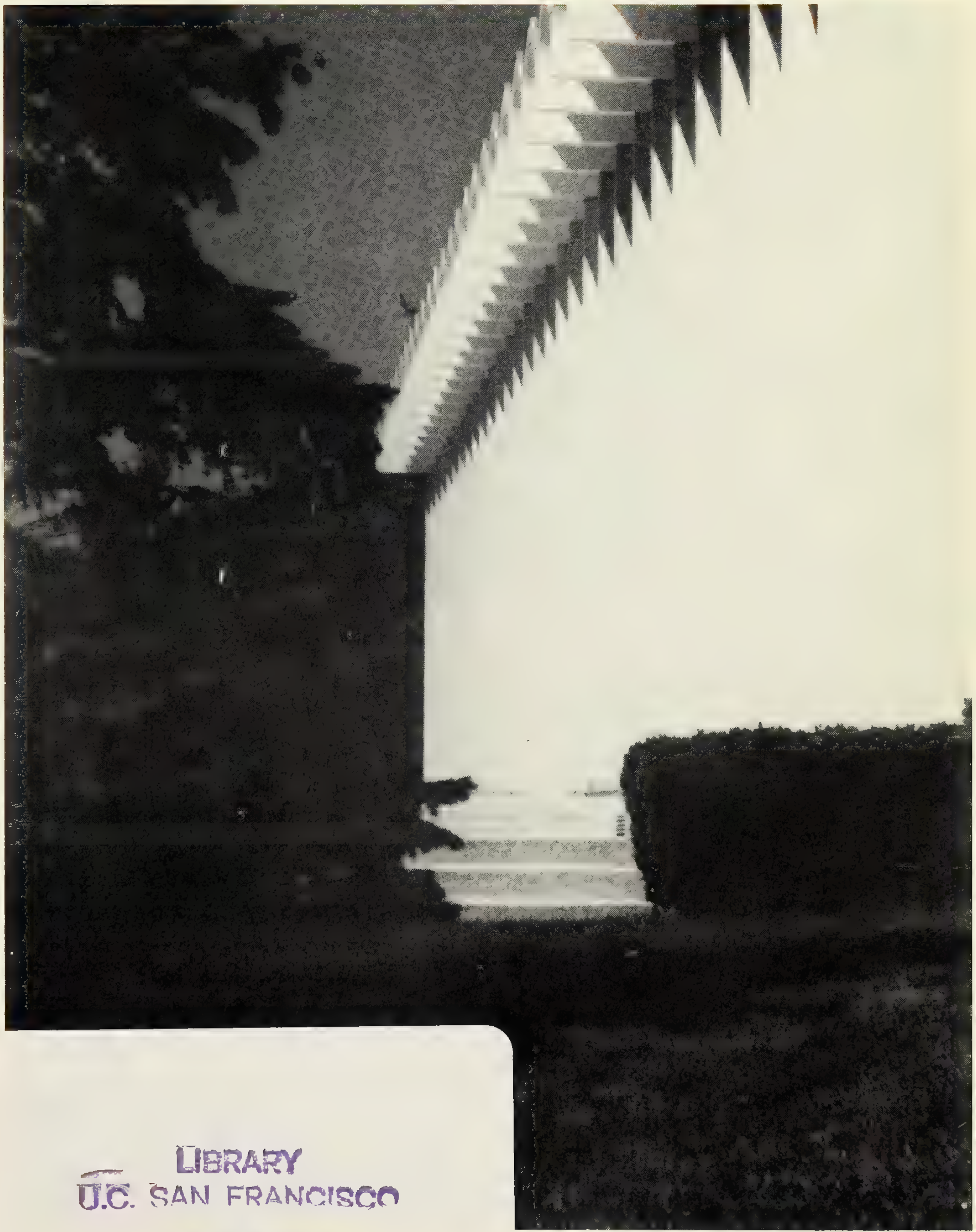
* * *

Alvin Tarlov, MD, University of Chicago medical school department head, advocates that anti-smoking efforts now cannot be measured effectively until children exposed to the campaign reach adulthood and their smoking habits can be measured. Doctor Tarlov, who spoke at AMA Congress on Medical Education, urged the anti-smoking forces to not give up now.

MSMS hasn't . . . we continue to mail many, many signs ("Caution: Your Smoking is Hazardous to my Health") every week to fill requests from doctors and many others.

MICHIGAN MEDICINE

FFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 6 JUNE 1976



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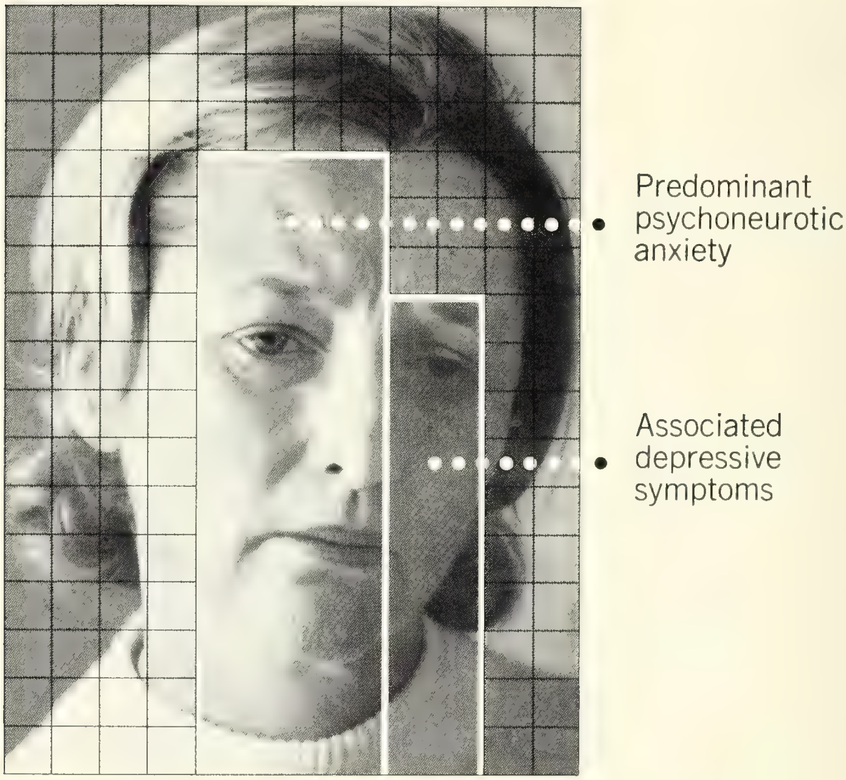
Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue

Michigan Medicine **celebrates the Bicentennial Year with a special issue designed to encourage physicians to enter more actively in our democratic process. Included will be features on county societies' legislative activities, the Doctor of the Week and MDPAC programs, MSMS lobbying and government agency liaison efforts and current MSMS efforts to influence legislation.**

Don't miss our Bicentennial issue.

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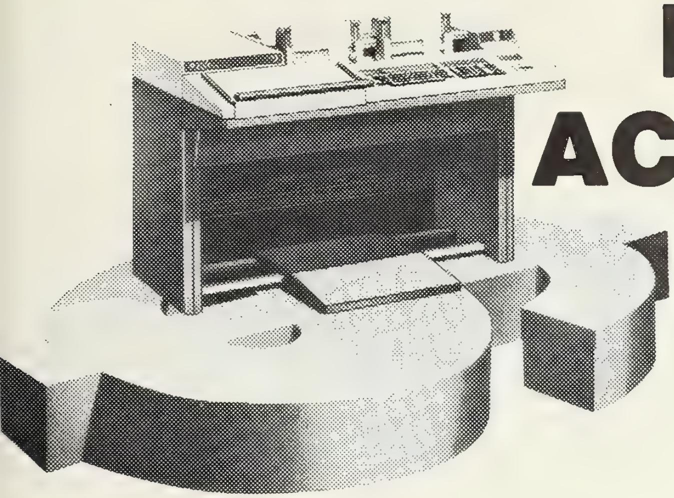

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Physicians constantly must guard against pressures from outside

Robert M. Leitch, MD
MSMS President

As physicians in today's troubled world, we must be continually vigilant and aware of the pressures from without. In the long run they constitute even greater challenge and threat to the very future of our profession. And if we forget to guard against them, we can become bogged down in the day-to-day implementation of our immediate programs and the pursuit of our individual practices.

It is almost impossible to listen to a speech these days which does not allude to "when we get national health insurance." I wonder about these statements because in the real sense we have national health insurance already in the form of Medicare, Medicaid, and the various other federal programs including HMO and PSRO.

These programs already are with us and, in a large part, appear to be here to stay. Further encroachment by the federal government on the medical profession must be constantly monitored.

We must recognize that there are great pressures for a change in the health care field. Recent Harris and other polls indicate that as high as 80% of those polled favor some sort of government involvement in the health care field. That is a fertile area for political cultivation. Legislators certainly will not overlook it.

We must recognize that some inequities do exist in the financing and delivery of health services. To the extent that the private sector is unable to offer solutions, the solutions will be forthcoming from government. Therefore, the private sector must constantly work to correct these inequities and thus decrease any necessity for further federal intervention.

The blind acceptance and implementation of an all-inclusive, Social Security-type approach as promulgated by some labor groups, Senator Kennedy and other legislators, must be opposed and exposed. We must support HEW Secretary David Matthews who recently told the House Subcommittee on Public Health and Environment: "There is no quick solution to the problem of health care financing, and attempts to find one before we fully understand the consequences could seriously impair the system we now have effectively insuring the vast majority of our population."

There appears to be confusion in the minds of many legislators and other people over the difference between health care financing and health care delivery. These differences must be pointed out lest we develop a system that will bankrupt the nation, hamstring us medically, and decrease the quality of medical care.

The lesson of the abuses and cost overruns of Medicare and Medicaid must be pointed out to the general public. It is in our own interest for doctors to take the lead in pointing out these abuses and the obvious pitfalls which will beset further federalization of medical care. But to a greater degree, we must encourage and convince our patients to study the issues and oppose more federal taxes and programs.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert** * **B. Greenblatt, M.D.**, and **D. H. Perez, M.D.**: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
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Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
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Potassium (from Potassium Sulfate)	2.5 mg
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ACTION AND USES DOSAGE: 1 tablet after breakfast and supper or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets.

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MSMS Report

How do you benefit as an MSMS member?

– *With your subscription to* Michigan Medicine *and* Medigram.

The most direct link between the Michigan State Medical Society and its members is forged by the MSMS publications, *Michigan Medicine* and *Medigram.* The two serve as a continuing source of news and information about MSMS activities and goals, medicine in Michigan, current issues in medical practice and socio-economic trends.

The monthly journal and the semimonthly newsletter complement each other, with the journal offering expanded and detailed discussion of the most critical of the short news items carried in the newsletter. For instance, the Oct. 17 *Medigram* announced the naming of six new members to the Michigan Medical Practice Board. The January issue of *Michigan Medicine* then carried several articles interviewing the new board chairman, its new executive director, and summarizing the biographies of the new members.

The first issue of *Michigan Medicine* was published in 1902, and from that time until recently, it was intended to serve primarily as a publishing vehicle for Michigan physicians and their original medical manuscripts.

Michigan Medicine consistently ranks among the best of state medical journals, in advertising volume and revenues, in editorial content, and in design. Its recent change to a strictly current-issue format drew good reviews from physicians, designers, publishers and writers.

The *Medigram* continues to present recent developments in crucial areas of interest to Michigan doctors in a short, concise form for easy reading. Occasional special issues are devoted to one subject, such as the recent special issue on actions of the 1976 MSMS House of Delegates.

Executive editor is Herbert A. Auer, manager, MSMS Department of Communications. Managing editor is Judith Marr. Policy decisions regarding the journal are made with the advice and counsel of the MSMS Publication Committee, chaired by James H. Tisdel, MD, Port Huron. On the committee are Busharat Ahmad, MD, Marquette; Noyes L. Avery, Jr., MD, Grand Rapids; James D. Fryfogle, MD, Southfield; and Thomas J. Setter, MD, Mt. Clemens. The committee has monitored all progress of the "New *Michigan Medicine*" and will continue to assess its impact and readership with MSMS members.

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Director

Just invested as 1976-77 MSMS president, wearing the shining silver mantle engraved with names of all MSMS presidents, Robert M. Leitch, MD, Battle Creek, addresses his family, friends and colleagues during the installation banquet. At right is Vernon V. Bass, MD, Saginaw, new MSMS president-elect.

Activity peaks in the House headquarters office when reference committees complete their reports, which must then be typed and reproduced for distribution to all delegates. Kenneth H. Musson, MD, Traverse City, committee chairman, works above with Beth Maleitzke, MSMS staff.

The MSMS Past President's Award, in honor of his year of service to MSMS during 1975-76, is presented to Brock E. Brush, MD, right, by Doctor Bass.

1976 MSMS House of Delegates' Annual Session

Six Saginaw health professionals received special awards from the MSMS House for saving the life of a workman in the Zilwaukee grain elevator explosion last winter. MSMS President Leitch, left at podium, read the citation before the House. Host of the honored guests was William A. DeYoung, MD, Saginaw, MSMS delegate, standing left. Those honored, from left, are Byron Spieth, RN; Charlene Sheehan, RN; Nola Pemberton, RN; Charlene Young; Robert F. Powers, MD, and Robert G. App, MD, all of Saginaw.

The rooms aren't so smoke-filled anymore (a 1972 MSMS House resolution banned smoking in the formal House sessions, as a matter of fact) but much of the discussion, study and decision-making still go on during delegate caucuses and reference committee sessions such as the one above.

Laughter traditionally closes the MSMS House of Delegates meetings as Delegate Harvey M. Andre, MD, Grand Rapids, reads his original, tongue-in-cheek resolution. Doctor Andre composes the resolutions in verse during the House meeting, and they refer to current events and issues.

Michigan Congressmen J. Robert Traxler, Bay City, left, and Philip E. Ruppe, Houghton, keynoted the annual MDPAC Luncheon May 1, one of the highlights of the 1976 MSMS Annual Session.

(The MSMS House met April 30-May 1 at the Troy Hilton.)

MSMS honors doctors graduated 50 years ago

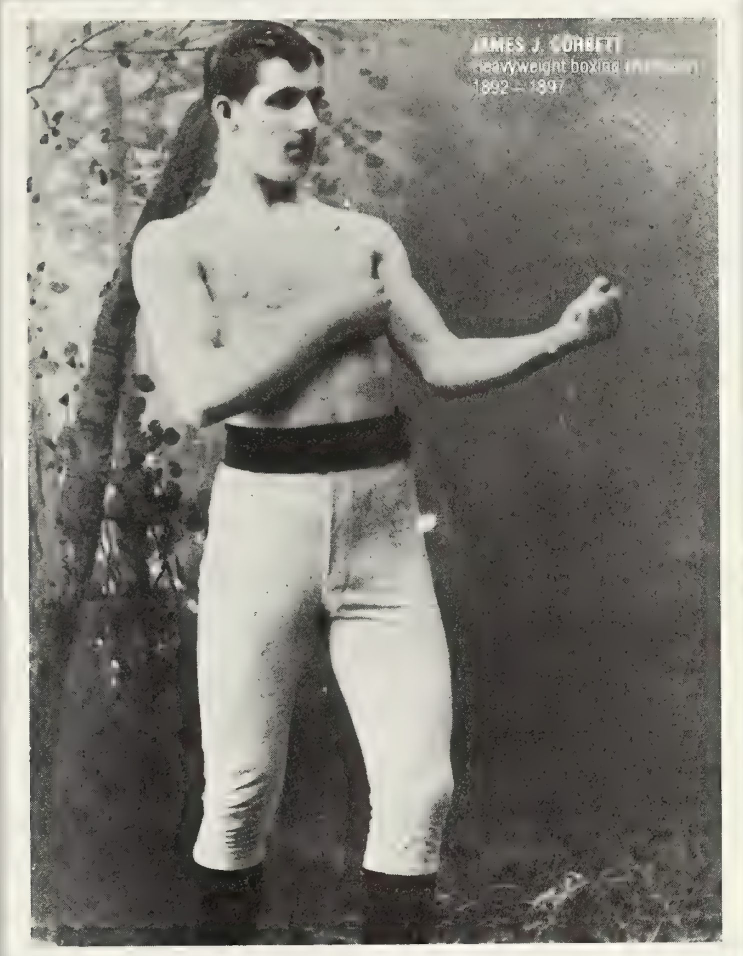
Nearly a century of medical service has been delivered by Leo Kallman, MD, Detroit neurologist, center, recipient of a 1976 MSMS 50-year award during special ceremonies May 1 in Troy, and his brother, R. R. Kallman, MD, right, Detroit internist, who will be eligible for his 50-year award in 1978. Keeping the medical tradition strong within his family is Steve Cohen, MD, new WSU Medical School graduate, grandnephew of Doctor Leo Kallman and grandson of Doctor R. R. Kallman.

The following MSMS members were graduated 50 years ago from medical school and are honored this year by the presentation of MSMS 50-year awards:

Norman H. Amos, MD, Augusta; **Sherman E. Andrews, MD,** Kalamazoo; **Helen S. Bernard, MD,** Muskegon; **Franklin W. Baske, MD,** Flint; **Harry B. Bennett, MD,** Southfield; **Sydney S. Berke, MD,** Detroit; **Robert H. Berman, MD,** Detroit; **G. Clare Bishop, MD,** Almont; **Chauncey G. Burke, MD,** Lakeland, Fla; **Lawrence H. Butler, MD,** Detroit; **James T. Cheng, MD,** Morristown, New Jersey; **Warren B. Cooksey, MD,** Troy; **Moses Cooperstock, MD,** Marquette; **Goldie Corneliuson, MD,** Ft. Meyers, Fla; **Carl W. Dahlgren, MD,** Waterford; **W. A. Dawson, MD,** Winter Haven, Fla; **Guy W. DeBoer, MD,** Grand Rapids; **Basil R. Dickson, MD,** Detroit; **Cornelius E. Dunn, MD,** St. Clair Shores; **Cecil W. Ely, MD,** Saginaw; **Robert T. Ewing, MD,** Monroe; **Stephen Fairbanks, MD,** Wellston; **Enid Fillingham, MD,** Muskegon; **Frederick J. Fischer, MD,** Detroit; **Michael A. Gertz, MD,** Ironwood; **Elisha S. Gurdjian, MD,** Detroit; **Albert E. Hammond, MD,** Detroit; **Roger J. Hanna, MD,** Mason; **Ernest C. Hansen, MD,** Manistee; **John C. Harkin, MD,** Marquette; **Shattuck W. Hartwell, MD,** Cleveland, OH; **Edward A. Hier, MD,** Alpena; **Aymer M. Hill, MD,** Grand Rapids; **Russell J. Himmelberger, MD,** Lansing; **George C. Hopkins, MD,** Harper Woods; **Nevin Huene, MD,** Jefferson City, MO; **Willis H. Huron, MD,** Iron Mountain; **Leo Kallman, MD,** Detroit; **Irving S. Katzman, MD,** Detroit; **Earl C. Kreig, MD,** Pompano Beach, Fla; **Harold H. Lampman, MD,** Detroit; **Laurence R. Leaver, MD,** Pigeon; **Meyer M. Levin, MD,** Southfield; **Barnard L. Lieberman, MD,** Sarasota, Fla; **Paul R. Lieberthal, MD,** Ironwood; **Clifford B. Loranger, MD,** Grosse Pte. Farms; **Francis B. MacMillan, MD,** Detroit; **Clarence E. Maguire, MD,** Harper Woods; **Edgar E. Martmer, MD,** Coloma; **James J. McClendon, MD,** Detroit; **Sophie Mishelevich, MD,** Warren; **Neal R. Moore, MD,** Bay City; **Richard D. Mudd, MD,** Saginaw; **Charles W. Oakes, MD,** Harbor Beach; **Randall M. O'Rourke, MD,** Warren; **Wesley G. Reid, MD,** Westland; **John L. Rosefield, MD,** Detroit; **Joseph N. Scher, MD,** Tamarac, Fla; **Louis A. Schwartz, MD,** Rockport, Mass; **Loren C. Sheffield, MD,** West Bloomfield; **Eugene L. Spoehr, MD,** Ferndale; **Clayton K. Stroup, MD,** Flint; **James Struthers, MD,** Farmington Hills; **James K. Sutherland, MD,** Flint; **Gabriel A. Tatelis, MD,** Detroit; **Harold E. Veldman, MD,** Grand Rapids; **Max H. Wainger, MD,** Detroit; **Leslie F. Wilcox, MD,** Grosse Pte. Park; **Maurice M. Wilde, MD,** Warren; **James L. Wilson, MD,** Ann Arbor; **Bertha A. C. Wiseman, MD,** Allegan; **Arthur A. Wittenberg, MD,** Detroit; **Donald C. Young, MD,** Northville.

50-year honoree Ernest C. Hansen, MD, Manistee, and his son, Vickers Hansen, MD, Manistee, MSMS delegate, admire Doctor Hansen's 50-year pin.

Famous Fighters



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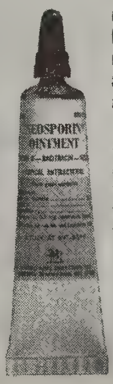
Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).



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Where MSMS stands on professional liability issues

Where does MSMS stand on professional liability insurance issues? Binding arbitration? A limited statute of limitations? Access to medical records? Patient responsibilities and rights? Support for physician countersuits in nuisance claims?

The answers to those key questions are contained in a new compilation of 27 MSMS position statements. The 27 statements were approved by the MSMS Council April 30 and then ratified by the MSMS House at its 1976 annual meeting in Troy. All 27 are reprinted here. They are designed to serve as a handy reference for MSMS members in their discussions about the professional liability situation.

"In every case," as MSMS Council Chairman Ernest P. Griffin, Jr., MD, points out, "the position statements have been written in a non-specific, general way so that physicians do not become hampered by, nor involved in, discussion of details."

No. 1: Brown-McNeely Termination Date

MSMS supports the state medical malpractice fund ("Brown-McNeely") to serve as an interim solution to the availability problem, but it should be dismantled as soon as the private sector can service the medical malpractice insurance market.

No. 2: Brown-McNeely Assessment of All Physicians

MSMS believes the Brown-McNeely fund should be financed by premiums paid by those physicians insured by the fund. If the fund fails to adequately estimate losses to be incurred, the State general fund should provide for re-financing rather than an assessment against all physicians whether or not insured by Brown-McNeely.

No. 3: Availability of Professional Liability Insurance

MSMS believes that a physician-owned and controlled professional liability company should be available to provide coverage in addition to coverage that may be available from commercial carriers.

No. 4: Professional Liability Reinsurance from AMA

MSMS supports the American Medical Association in its efforts to assure reinsurance through a new company.

No. 5: Statistical Disclosure by Professional Liability Insurance Companies

MSMS believes all insurers should disclose pertinent statistical information on claims, settlements and judgments.

No. 6: Arbitration – Binding Arbitration

MSMS supports a dual system for handling of malpractice claims, with either voluntary binding arbitration or courtroom litigation available.

No. 7: Arbitration – MSMS Supports Implementation

MSMS vigorously promotes use of voluntary and binding arbitration to give it a fair trial as a means of resolving malpractice complaints.

No. 8: Arbitration – Component Societies Monitoring

It is official MSMS policy that each component society should establish its own arbitration implementation committee, to have at the local level sufficient expertise and interest to closely monitor arbitration as it is effected in Michigan.

No. 9: Arbitration – Professional Panel Member Criteria

MSMS believes the panel of medical arbitrators available for selection by parties to an arbitration proceeding should be as broadly representative of all medical disciplines as possible.

MSMS believes the panel of attorney arbitrators available for selection by parties to an arbitration proceeding should be as broadly representative of all legal disciplines as possible.

No. 10: Arbitration – Public Members on Panel

MSMS encourages civic-minded members of the public to volunteer to serve as panel members in professional liability arbitration.

No. 11: Definition of Malpractice

Legislate a clear definition of malpractice, to differentiate malpractice from a poor result.

No. 12: Limited Statute of Limitations

MSMS supports efforts to establish by statute a fixed statute of limitations for all persons over the age of eight (8).

No. 13: Alternative to the Contingency Fee System

MSMS believes that organized medicine, with the Bar if possible, should seek an alternative to the contingent fee and thus the ultimate elimination of the contingency fee system at an appropriate time for

(Continued on page 310)

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legislative change or modification of our traditional system of jurisprudence.

No. 14: Regional Restriction on Expert Witnesses

MSMS supports legislation which would limit the use of medical expert witnesses to those experts who are in fact acquainted with the relevant standards of practice in the community situs of the claimed malpractice, or with the standards of a comparable Michigan community.

No. 15: Waiver of Physician-Patient Confidentiality

MSMS favors legislation to waive any physician-patient confidentiality privilege and/or hospital privilege concerning the patient's mental or physical condition at the date a malpractice action is filed. This would make available medical records of all physicians and hospitals with whom the patient has been treated in the time period embraced by a malpractice complaint.

No. 16:: Access to Medical Records

MSMS favors legislation to systematize quick access to medical records by plaintiff attorneys prior to filing of a medical malpractice suit to facilitate the bringing of meritorious actions and inhibit the filing of nuisance suits. "Medical records" means the record of medical care and treatment maintained by a physician, hospital, or allied personnel defined in existing rules of the Department of Public Health, except that information used specifically for educational, research and experimental purposes may not be subject to discovery.

No. 17: Study of Professional Liability by Health Planning Advisory Council

MSMS supports continued study and monitoring of professional liability problems by the State Health Planning Advisory Council, or its successor, as recommended in 1975 by Michael Dively for the Governor.

No. 18: Miscellaneous Legislation (1975)

MSMS favors vigorous implementation of legislation enacted in 1975 pursuant to the "Dively Report," to wit:

1. Reporting of disciplinary actions by hospitals, medical staffs and professional societies.
2. Immunity for all persons serving on peer review, PSRO, or other medical review entities.
3. That the public be informed of its rights and how to file complaints with the Medical Practice Board.

No. 19: Patient Responsibilities and Rights

MSMS study development of a statement of patient's responsibilities and rights which will effectively communicate all those responsibilities and rights to all patients.

No. 20: Monitoring of Expert Witnesses

MSMS believes the quality of expert medical testimony needs to be monitored by the profession to assure competency. The appropriate component medical society and/or specialty society will be requested to monitor the testimony or review the deposition and render a written report on the quality of the testimony to the MPMLC Board and/or a task force of MSMS for review and appropriate action.

No. 21: Support for Physician Countersuits in Nuisance Claims

MSMS believes it should support physicians who are considering countersuits against a plaintiff or attorney, or both, following malpractice cases totally without merit.

As MSMS cannot itself bring such a suit, it could assist the physician and his attorney by providing expert medical and legal review and research to support and encourage aggrieved defendant physicians in bringing counter actions.

No. 22: Affidavit of Merit

MSMS favors a statutory requirement that the plaintiff must provide an affidavit by an expert witness attesting to the merit of a complaint at the time a complaint is filed. This would be a strong deterrent to frivolous or nuisance complaints.

No. 23: Ceiling on Awards for Pain and Suffering

Establish, through legislation, ceilings on pain and suffering awards, however, in a proven malpractice case, MSMS believes that actual damages should be awarded.

No. 24: Permit Annuity Payments of Professional Liability Awards

Seek legislation to permit discretionary annuity-type payment of awards in malpractice judgments rather than lump sum payments as in existing arbitration legislation.

No. 25: Burden of Proof

MSMS favors legislation to require with specificity that malpractice, as defined in Point 11, must be proven by the plaintiff before a verdict may be granted to the plaintiff.

No. 26: Continuing Medical Education

1. MSMS commits itself to aid members of the profession to attain the required number of hours of continuing medical education, with special emphasis on 25 hours of Category I.
2. MSMS favors amendments to the statutory requirement for 50 hours annually modifying the requirement to 150 hours in a three-year period. This is a wiser criterion for measuring continuing medical education, and fits with almost all specialty society requirements.

No. 27: Medical Practice Board

1. MSMS favors full funding of the Medical Practice Board from existing income so that the responsibilities of the 1973 Medical Practice Act can be fully implemented before new changes in the law are effected.
2. MSMS deplores meddling with the 1973 Medical Practice Act, which MSMS helped to create, by laypersons or others lacking knowledge or concern for the intricacies of licensing medical practitioners.

welcome

(New members of the Michigan State Medical Society)

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Detroit 48224

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Kingsford 49801

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Michael A. Marshall, MD
6500 John C. Lodge
Detroit 48201

(Continued on page 320)

"You surgeons must have nimble fingers."

Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct nontherapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

Genesee doctors beat feds at own game; true peer review is working for them

By Merwyn Scholten
MSMS Communications Department

Some farsighted thinking on the part of several doctors comprising the Genesee County Medical Society's long-range planning committee is today a living, active reality named the Genesee Medical Corporation.

The Genesee Medical Corporation was established to provide better medical care, better service to patients and better service to physicians in the three-county area it serves. And it all started well before the federal government instituted the PSRO concept.

It should be noted that GMC is *not* a PSRO. A separate corporation, the Professional Review Organization-GLSC (for Genesee, Lapeer, Shiawassee counties) was formed by the GMC in September of 1974, for the express purpose of contracting as a conditional PSRO. The officers of GMC realized that federal PSRO rules and regulations would create problems within the structure of the GMC which was created to do several things and therefore the decision to form a separate corporation.

Frederick W. Van Duyne, MD, is president of both corporations and Donald R. Blass is executive director for both corporations. GMC currently has some 380 MD members.

The GMC's Projects

Just what is the GMC doing? It has four on-going projects and is investigating several others which it soon hopes to undertake.

On Oct. 1, 1975, GMC signed an agreement with Healthco (a major medical, surgical, and equipment supplier) which permits member physicians to purchase many items at a considerable savings by taking advantage of volume purchases.

Physicians already participating in the program are reporting savings of approximately 20 per cent. Doctor Van Duyne is optimistic for the future of the plan. "We hope that the volume buying will enable doctors to help hold the line on health care costs by effecting some savings which will offset rises in other business costs."

A similar arrangement with a local office supply firm provides for up to a 24 per cent discount on purchases of routine supplies needed in the normal business office activities.

One of the major programs now going on is the Impartial Medical Opinion Program under which GMC physicians conduct some 1,000-1,400 exams per month for the General Motors employees in the Greater Flint area. Under the program GM sends employees seeking sick leave compensation to be evaluated by one of the program physicians for an impartial opinion on the employee's health status. About 10 per cent of the reported ill employees are sent to the program.

"Both GM and the unions are pleased with the program," says Doctor Van Duyne "because it has helped stem unnecessary absenteeism." An employee who is truly unable to work because of illness or injury has nothing to fear from a professional impartial review of his case and the chronic malingerer "gets well" in a hurry once he is scheduled to appear for the exam. GM reports that 50% return to work before their scheduled review appointment.

GMC personnel handle all the arrangements and follow-up details on these IMOP activities.

Any physician or clinic wishing to computerize claims and statement preparation can do so by taking advantage of the GMC contract with Computer Consulting Service, Inc.

On December 30, 1975, the GMC signed a contract with Blue Cross/Blue Shield of Michigan to conduct an admission and concurrent review program for all Blue Cross and Blue Shield of Michigan subscribers receiving acute care in Flint Osteopathic, Genesee Memorial, Hurley Medical Center, Lapeer County General, McLaren General, Memorial-Owosso, and St. Joseph hospitals. Between them, PRO-GLSC and GMC monitor about 90 percent of the admissions to these hospitals. Included are Medicare, Medicaid, Crippled Children and the BC-BS admissions. Purpose of the program is to assure appropriate medical services are rendered at the appropriate level of care.

Some 84 different physicians serve as the physician advisors in the seven hospitals in which PRO-GLSC has its review coordinators. The program utilizes 26 review coordinators and nine review clerks to review over 8,000 admissions per month at an average cost of $8-$12.

The 12-doctor GMC Board is comprised of three DO's and three MD's each elected from their county society executive committee and six physicians elected at large.

The Board of Directors of PRO-GLSC is comprised of 11 MD's, 5 DO's and two consumer representatives. Membership in PRO-GLSC is 477, which represents 63% of the total practicing physicians in the three-county area.

GMC and PRO-GLSC share office space, employees and equipment with proper cost-accounting procedures assuring that correct charges to each corporation occur each month.

More programs to come

In addition to operating all of the foregoing projects, GMC is looking into the merits of several additional activities:

1) establishing a new physician answering service;
2) conducting a study into the feasibility of an Independent Practitioner Association HMO as an appropriate alternative for prepaid health care;
3) developing a nursing home review program which will assure appropriateness and quality of nursing home care.

GMC leaders are hopeful that this last project will be operational and funded by mid-summer.

While many physicians are apprehensive about peer review as they consider federal mandates for the concept, GMC physicians who took the bull by the horns are discovering that true "peer" review can work and is working for them.

"If doctors get together and work together in their mutual interests and in the best interests of their patients, great things can be accomplished without government having to step in," says Doctor Van Duyne. "And the GMC and its co-corporation the PRO-GLSC are the answer to our tri-county area's needs to work together."

It is of interest to note that aside from the federal contract to operate as a conditional PSRO and conduct the reviews for which it is being paid, there is no federal money tied to the GMC itself. An initial grant from Regional Medical Programs and a $100 physician membership in the corporation supplied the GMC with the startup money needed to begin operations.

"We believe GMC and PRO-GLSC are examples of what the private sector can do in the face of continuing government encroachment in medical care," says Doctor VanDuyne. "We believe we can do our job well at less cost than any federal program could do. And while we do not pretend to have all the answers to quality assurance or any other program, we truly believe concerned physicians across Michigan and the nation should get together to develop their own programs to meet the needs of physicians and the patients they serve."

AMA-MSMS Category I Course July 17-18 for UP physicians

At the request of MSMS, the AMA has agreed to conduct one of its regional continuing medical education programs July 17-18 in Michigan's Upper Peninsula. The six Category I courses presented on those days will assist Michigan physicians in meeting their requirements for 50 hours of CME credit per year.

The classes are scheduled for the Northern Michigan University Center in Marquette. A block of rooms has been reserved at the Ramada Inn in Marquette for participants' lodging.

Subjects of the courses are "Pediatric Use of Common Drugs, Diagnosis and Treatment of Arrhythmias and Management of Coronary Artery Disease, Critical Patients, Oncology for the Practicing Physician, Infectious Diseases," and "Office Gynecology."

The charge is $10 per credit hour, which includes breakfast and luncheon on Saturday, breakfast and coffee break on Sunday. Further information may be obtained from Herbert A. Auer, manager, Continuing Medical Education Programming Department, MSMS, Box 950, East Lansing 48823.

MSMS participating in swine flu vaccination effort

MSMS will be among the major participants in the state's drive to vaccinate all citizens against the dreaded swine flu epidemic. The state medical society joined representatives of approximately 35 organizations May 21 at the initial planning session for the immunization effort.

The MSMS Council on April 30 voted to support the immunization of the Michigan population against a New Jersey (swine) influenza and cooperate with the Michigan Department of Public Health in developing such a program. The Council learned from John L. Isbister, MD, State Disease Control Officer, that the vaccine should be ready in late summer or early fall.

Community interest in the vaccination program is high, according to Maurice S. Reizen, MD, MDPH director. As plans are developed, the MDPH will keep local health departments, physicians and other health personnel informed as to the needs and opportunities for cooperative action.

In the meantime, the health department suggests physicians keep the following information in mind in dealing with patients' questions:

1) The virus that causes concern is not the one that causes influenza in swine. The term "swine" influenza arises from the fact that the strain was first isolated from swine and carries an antigen relating it to the influenza that occurred in 1918-19. The influenza in swine due to this virus has little infectivity for man. The virus of concern was isolated under circumstances of person-to-person transmission, which means that a virus with the antigenic characteristics of the 1918-19 strain has at least entered the human chain. The strain now should be referred to as A/New Jersey.

2. There is no way of telling how likely there may be an epidemic of influenza due to this strain next winter, or if it does occur, how severe the disease will be. The national program is based on the principle that if we are to prevent epidemic influenza we must be prepared to act even if we don't know all of the answers. It is better to have performed widespread immunization even if an epidemic does not occur than to wait until we are sure an epidemic is coming when it will undoubtedly be too late to do anything about it.

3. No vaccine for the "swine" influenza is available now, nor will it be for some months. Time must be spent now in preparing for the administration of the vaccine while the manufacturers are producing it.

4. The medical profession will be asked to play a significant role in this massive program. The guidelines for the program are now being developed and medical societies will be contacted as soon as plans can be developed. The Michigan Department of Public Health and the county health departments will be responsible for the organization of the program, but its execution will depend on the cooperation of the medical profession and community volunteers.

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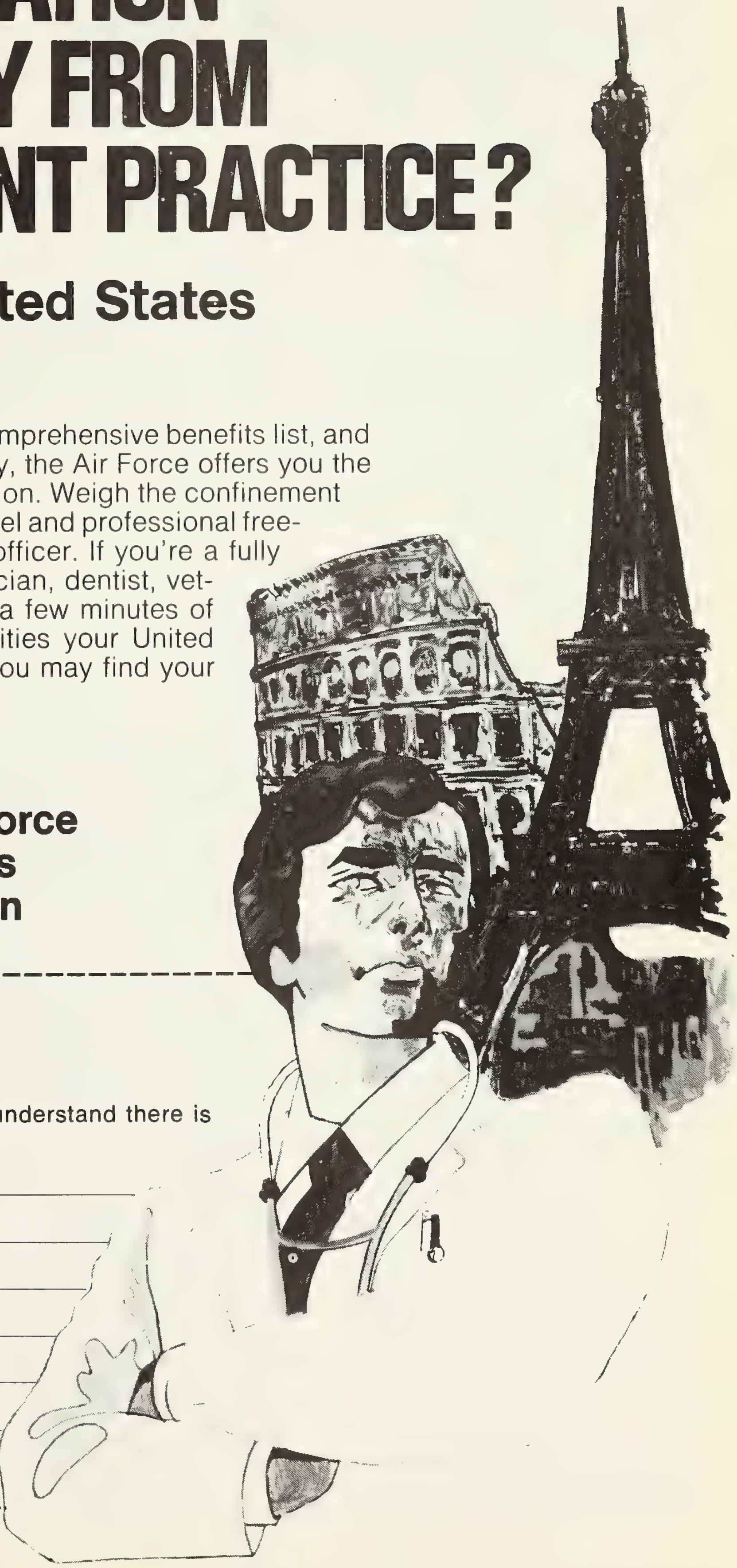

PRACTICE MANAGEMENT

Billing how-to's

By R. Timothy Hogan
Ann Arbor

Are your collections dropping?

Most physicians assume that patients are grateful for medical services performed and they will pay the fee submitted. This is not necessarily the case.

With the rapid rise in installment debt, inflation, and unemployment, many people simply run out of money before they get all of their bills paid. Fees for medical services tend to fall to the bottom of the budget when bill-paying time rolls around unless you take steps to change the spending sequence of your patients.

The paper-work crunch has hit most professional offices and involvement of third-party payors has increased significantly over the years. The result in many cases is that collection techniques have been downgraded to a haphazard mechanical task.

I suggest that you re-examine your collection procedures to see if they are really working. Do you know your current collection percentage? You must have a system that adapts itself to your particular practice in order to assure that your collection efforts are productive. This does not mean that you should lose sight of the fact that most patients are honest and appreciative of your services. They will pay if your collection system encourages payment in a courteous manner.

When patients leave your office without paying, they have in effect, asked you to grant them credit. Consequently, you are running a business and are in the same position as other credit granters. However, the physician is different from most others in at least two respects:

1. Your service, for the most part, is non-elective and usually the patient would much rather not have to use it.

2. Your service, once provided, is intangible and cannot be repossessed.

Many offices routinely have new patients fill out an information form providing name, address, telephone number, birth date, family, spouse, referred by, employment, and insurance company and policy numbers. This provides information necessary for preparation of financial records.

A basic premise to be remembered is that the best time to collect your fee for office procedures is at the time of service. This also helps to contain rising operating costs. A discrete notice might be posted at your reception desk requesting payment at the time of service.

Upon leaving your office, all patients should be instructed to stop at your reception desk. The use of a charge or service slip, marked by the physician with today's charge and request for future appointment, facilitates this procedure. The receptionist then informs the patient of any prior balance and the charge for today. This usually results in a positive response. Never say to a patient, "Do you want me to bill you later?"

The use of an unstamped, return envelope for an account with an outstanding balance is another collection tool. This can be used in conjunction with a peg-board system receipt charge slip, and would eliminate billing for that particular month.

When possible, patients should be informed of the fee for surgery, diagnostic and elective procedures before the service is performed. If the service is not covered by insurance, the patient should be informed, and a payment plan arranged. This is helpful to the patient as well as the physician.

Follow-up procedures are necessary for accounts with an outstanding or delinquent balance. The longer an account runs the less likely the bill will be paid. Itemized statements should be sent at a regular time each month.

Follow-up is still required for the slow paying or non-responsive patient. Always be courteous. You can be firm and businesslike and continue to keep the patient's good will. Collection letters or inserts still get good results if they exert a positive tone. The debtor should know how much is owed, and also what, where, when, and how the account should be liquidated. Finally, a reputable collection agency may be needed. However, if the collection agency collects a high percentage of your accounts, it may mean that your office system is not adequate.

It is essential in most practices today that you have a system for billing and follow-up to third party payors. You should have an insurance aide who is well-informed and keeps up to date on revisions. Insurance forms should be prepared regularly after covered service is performed, not once or twice a month. The physician should also review and sign these forms on a regular basis. An insurance log might be instituted that lists name, insurance company, when service was completed, date form filed, status inquiry and date paid. It is not uncommon to charge for the preparation of more than one insurance form. In certain circumstances, the use of a standard insurance form and assignment of benefits may be helpful. Properly prepared and filed insurance claims are one of the best ways to maintain a good cash flow.

Mr. Hogan is a consultant with Professional Management, Black and Skaggs Associates, Ann Arbor.

Heartbeat

Clement A. Fox, MD, Detroit, professor and former chairman of the department of anatomy at the Wayne State University School of Medicine, presented the Gordon H. Scott Memorial Lecture last month. His topic was "Golgi Studies on Brain Centers: Retrospect and Prospect." This was the fourth annual lecture in the series which each year selects a distinguished medical researcher or scholar to give the presentation in honor of the late Gordon H. Scott, MD, former chairman of the WSU anatomy department prior to becoming dean of the medical school.

* * *

John Moses, MD, Detroit, president of the Wayne County Medical Society, and a member of the Michigan Medical Practice Board, has been named to the AMA's new Ad Hoc Committee on Medical Discipline. The 10-member committee is charged with the task of studying the disciplinary mechanisms of medical associations to determine their effectiveness. Also under study will be state licensure board regulations and hospital privileges. When all study has been completed, the committee is to present recommendations for improvements in the medical profession's self-regulating and self-policing mechanisms.

* * *

Francis L. Purcell, MD, Ypsilanti, is new second vice president of the American Occupational Medical Association. Doctor Purcell is the medical director of the General Motors Hydra-Matic Division in Ypsilanti. The 3,600-member association is an international organization of physicians who provide health care for the employees of private enterprises, governmental services and other institutions.

* * *

Garfield Tourney, MD, Detroit, is the newly-installed president of the Michigan Psychiatric Society, having taken the office May 15. **Elliot D. Luby, MD, Detroit,** is the new president-elect of the group.

* * *

John K. Winter, MD, and William G. Winter, MD, Holland, were honored on April 29 by their former patients and friends in the community. The twin brothers who practiced medicine in the community for 40 years were warmly greeted by some 2,000 patients and friends in a special "Appreciation for a Pair O'Docs" day April 1. Congratulatory messages and official proclamations were received from congressmen, senators, state legislators, Governor Milliken and Lt. Governor Dammon, and the U.S. Surgeon General on behalf of President Ford.

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Robert M. Zimmerman, M.D.

MPMLC welcomes physicians' applications for insurance policies

The Michigan Physicians Mutual Liability Company now welcomes applications for policies from all physicians who are members of MSMS or the Michigan Association of Osteopathic Physicians and Surgeons.

The MPMLC officially was certified May 12, and the state insurance commissioner followed with approval of premium rates and classification systems on June 4.

MSMS or MAOPS members in good standing, who purchase surplus certificates with the MPMLC may obtain applications for coverage by contacting the MPMLC directly at Box 1471, East Lansing 48823, or calling (517) 351-1150.

Physicians who have not yet purchased surplus certificates, which are required before a physician is eligible for coverage, may do so also by contacting the MPMLC.

"The MPMLC will operate with the physician's viewpoint, make decisions with doctors in mind and be run by physicians for physicians," says Vernon V. Bass, MD, president, MPMLC.

"We are confident that our company will make Michigan more attractive to new physicians and those seeking to relocate, will vastly improve the practice of medicine in Michigan and thus improve our services to the people of Michigan."

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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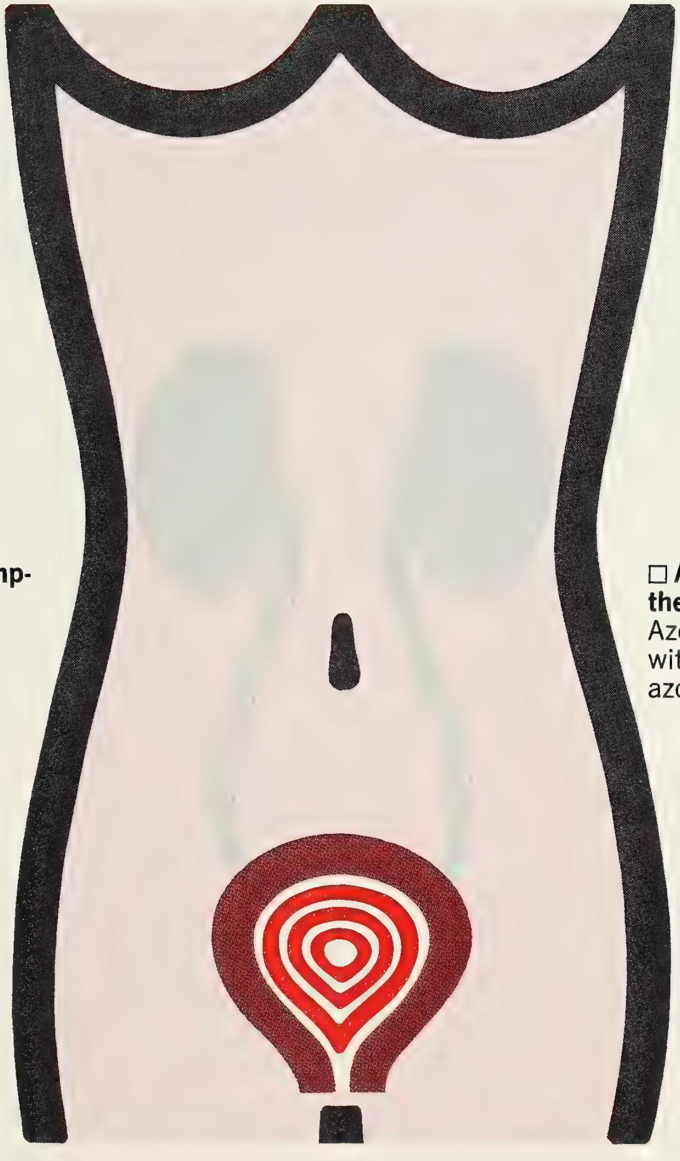

☐ **Early relief of painful symptoms** such as burning and discomfort associated with urgency and frequency.

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

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Serum K+ and BUN should be checked periodically. (See Warnings Section.)

SPARES POTASSIUM

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

> *Warning
>
> This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

*Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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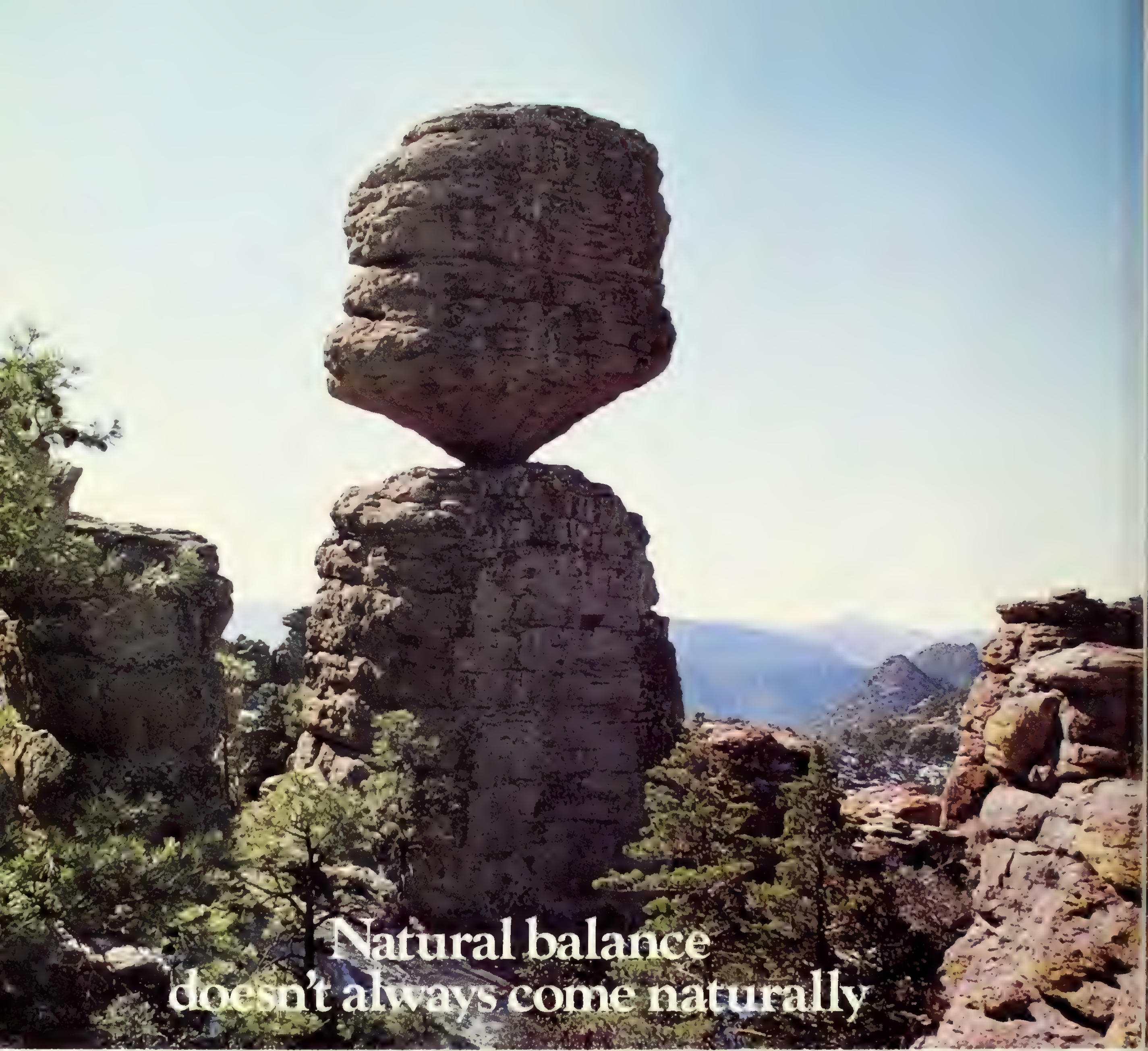

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☐ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
☐ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences – National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

How to be a good consumer of CME programs

By Floyd Pennington, PhD
Ann Arbor

Physicians are now consumers of continuing medical education. The kind of consumer the physician chooses to be is a personal decision. The problem is not a lack of potential alternatives, it is a matter of careful selection. The physician can consciously plan his "shopping" list or accumulate 50 hours in a random manner. A planned approach to fulfilling the requirement will be an educational service to the physician and will save time and money in the midst of a busy medical practice.

Leonard Stein (1973) prepared a very useful guide to help individual physicians develop efficient plans for their continuing education. Stein suggests seven steps:

1. Determine your needs.
2. Assess your practice.
3. Select specific learning objectives, on the basis of the first two steps.
4. Decide how to achieve each learning objective.
5. Inventory learning resources available to you.
6. Decide the priorities and establish a schedule.
7. Evaluate your learning achievement.

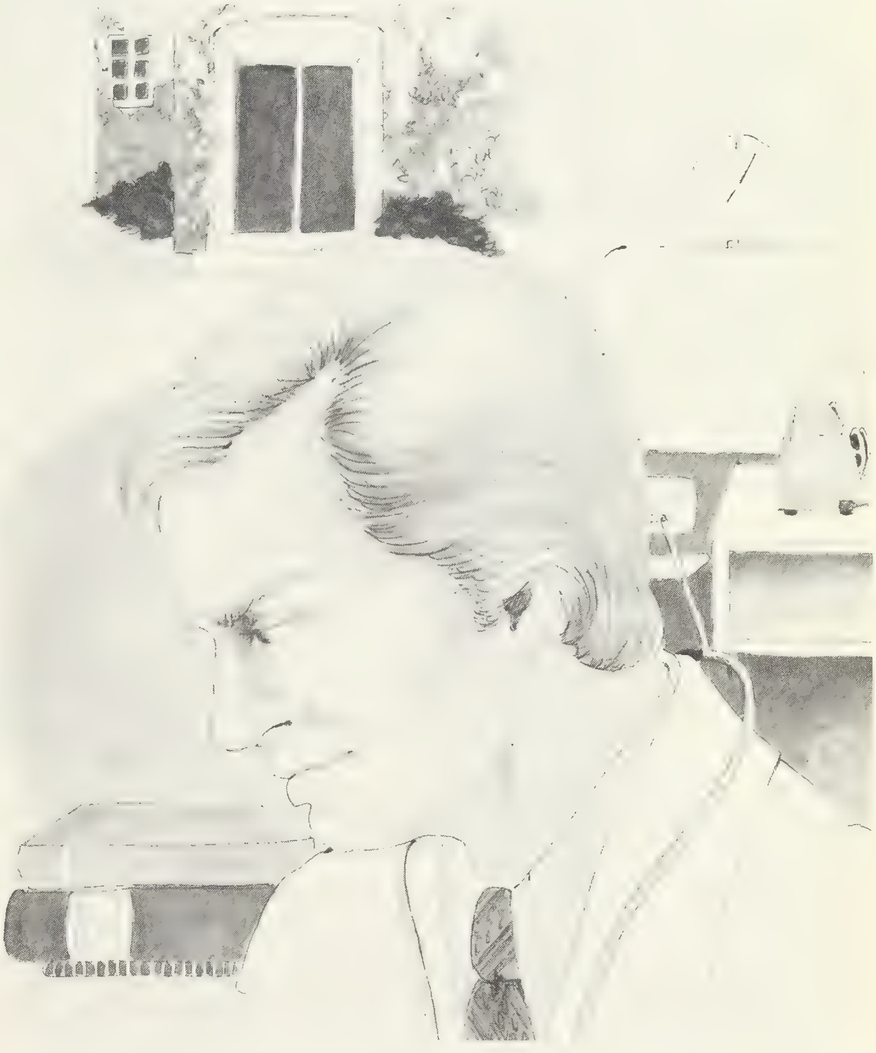
These suggestions, or ones tailored to the individual's learning style provide a positive approach to fulfilling the legal requirements of the Michigan law.

A rational plan will be helpful. However, the thoughtful consumer will ask a number of other questions before he purchases a product. One of the first questions to ask is *"How do I learn most effectively?"*

Each of us has been subjected to a variety of instructional methods. For some physicians, the lecture is the most effective and efficient way to learn. For others, grand rounds, slide-tape programs, computer-assisted instruction, workshops, seminars, conferences, or audio-digest are preferred learning styles. How one learns best is something the individual must ascertain for himself. To suffer through a video-tape because I can get credit even though this teaching format puts me to sleep is a waste of valuable time, will result in no learning, and violates the spirit of the legal requirement.

"What will the learning activity cost?" This cannot be calculated on registration fees, travel and lodging alone. Costs include the necessary arrangements with others to cover emergencies that may arise while you are away in another city attending a course. Costs include time away from practice and family. Potentially, the most cost effective and efficient learning activities will be those planned and conducted at the local level. This is where your practice is. Include a fair proportion of these activities in your plan. If none exist, explore options available to change those circumstances.

"What can I legitimately expect from continuing medical education activities?" Many continuing education activities present a relatively small amount of "new" information. Quite often these activities are de-



Pen and ink wash by Jann Lardie

Doctor Pennington is assistant director, Office of Intramural Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical Center.

signed to consolidate information and suggest improvements in clinical practice. The patient benefits from this as the physician gains precision in diagnosis and treatment skills. The physician gains from this in time savings. That time might be reinvested in learning about the particularly interesting problems which could be new primary care activities.

"What do I know about the learning activity?" Examine the program's publicity very carefully. Are the objectives clearly stated? Will the stated objectives meet your personal and professional learning needs? Does the publicity indicate that the instruction is the kind you prefer to use in learning? Do the instructional methods seem appropriate to the subject matter? Does it appear that the activity is at a level you would find useful — not too easy, not too difficult? Who are the faculty members that are responsible for leading the activity? Will these people provide the learning opportunities you feel are needed to improve your patient care activities?

It may be unreasonable to ask all of these questions about every activity. If you do not find information you need in publicity material, then call the sponsor. Obtain the information you need before you commit your time and money to the activity.

"What do I know about the sponsor of the learning activity?" Each sponsoring agency of continuing medical education activities has unique strengths. Medical schools emphasizing research and teaching will be strong in the dissemination and utilization of new information. Professional societies concerned with maintaining high standards of professional practice will emphasize activities that will have immediate use in clinical practice. Commercial sponsors will be interested in activities that show the utility and efficiency of products. Community hospitals will be interested in activities that will improve medical practice in the hospital setting.

Physicians should know what the strengths are of various sponsors. Publicity will usually reveal these strengths, but not always. Be confident in the fact that the sponsor will be able to provide the type and quality of educational experience you feel is essential.

The physician does not have to accept poor quality educational activities. If you find yourself in a substandard activity, vote with your feet — leave and don't return to other programs sponsored by that group. You will have ample opportunities to fulfill your 50-hour requirement. Program sponsors are responsible for the efficacy of their programs. Let your judgments be known. Sponsors must listen and be responsive if they are going to stay in business.

The comments in the preceding paragraphs are intended to assist the physician in becoming a proficient consumer of continuing education activities. As you select your criteria for selecting experiences to fulfill the mandatory continuing education requirements, do so as an informed consumer.

Reference

Stein, Leonard *Your Personal Learning Plan: A Handbook for Physicians.* Chicago: Illinois Council on Continuing Medical Education, 1973.

The categories of creditable educational activities that will meet the requirements are similar to the six AMA categories established for the Physicians' Recognition Award. The categories and the maximum credit hours that may be earned in each category are:

Category I:	**Continuing medical activities with accredited sponsorship — 50 hours**
Category II:	**Continuing medical activities with nonaccredited sponsorship — 12 hours.**
Category III:	**Teaching medical physicians or the allied health services — 16 hours.**
Category IV:	**Books, papers, publications, exhibits — 15 hours.**
Category V:	**Nonsupervised: Self-assessment, self-instruction, specialty board examination preparation, quality care and/or utilization review — 12 hours.**
Category VI:	**Full-time participation in a graduate training program — 50 hours.**

A minimum of 25 credit hours of the total 50 hour requirement must be earned in Category I or Category VI. The remaining 25 hours may be earned in any category, I through VI. These six categories permit a number of alternative activities which can be selected to fulfill the requirement. Physicians are free to select any activity they wish as long as the mix of activities meets the requirements at the end of the year.

Here is a list of all Michigan institutions that have been approved to offer Category I continuing education credit.

Alma-Gratiot Community Hospitals
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic/Little Traverse Hospital and Medical Center, PC, Petoskey
Butterworth Hospital, Grand Rapids
Henry Ford Hospital, Detroit
The Grace Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Michigan State University College of Human Medicine
Mt. Carmel-Mercy Hospital and Medical Center, Detroit
Pontiac General Hospital
Saginaw Cooperative Hospitals, Inc.
Edward W. Sparrow Hospital, Lansing
St. John Hospital, Detroit
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
The University of Michigan Medical Center
Ypsilanti State Hospital
Wayne County Psychiatric Hospital, Eloise
Wayne State University School of Medicine
MSMS Committee on CME Programming

category 1 programs

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

DATE: June 21-25, Northern Michigan Summer Program
LOCATION: Shanty Creek Lodge, Bellaire
SPONSOR: U-M Office of Intramural Education
COST: $200
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 22½ hours of Category I credit

* * *

DATE: June 23, Symposium, Socio-Medical Management of the Geriatric Patient
LOCATION: Sheraton-Southfield Hotel, 17017 W. Nine Mile Road, Southfield
SPONSOR: American Geriatric Society
FOR: All physicians
COST: None
CONTACT: Jack Strahan, Medical Service Representative, Roerig Co., 2901 Victor Ave., Lansing 48910
APPROVED FOR: 4 hours of Category I credit

* * *

DATE: June 24-25, Professional Health Practices and Their Impact On Aging
LOCATION: Lansing Hilton Inn
SPONSOR: American Public Health Association, Michigan Office of Services to the Aging, Michigan State Medical Society, and Genesee County Community Mental Health Services Board
FOR: General Practice, Psychiatrists, Internists
COST: $20
CONTACT: State Aging Office, (517) 373-8560
APPROVED FOR: 11 hours of Category II credit

* * *

DATE: June 30, Family Practice Conference on Hypertension
LOCATION: E. W. Sparrow Hospital, Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All Physicians
COST: No fee; luncheon preregistration limited to 70.
CONTACT: Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, Lansing, 48902
APPROVED FOR: 4 hours of Category credit

* * *

DATE: June 30, Symposium on Sudden Infant Death Syndrome
LOCATION: McGregor Memorial Conference Center, Wayne State University
SPONSOR: WSU School of Medicine Department of Pathology and the Michigan Regional SIDS Center
FOR: Family physicians, pediatricians, pathologists, medical examiners
COST: $45
CONTACT: Beaufort Cranford, Profram Coordinator, WSU, Detroit, 48202
APPROVED FOR: 6 hours of Category I credit

* * *

DATE: June 30-Sept. 8 — Instrumentation in Clinical Biochemistry (2 hours weekly)
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
SPONSOR: WSU Department of Pathology
FOR: Hospital pathologists
COST: $154
CONTACT: WSU Continuing Medical Education**
APPROVED FOR: Hour-for-Hour Category I Credit

* * *

DATE: July 7, 14, and 21, Preventive Medicine
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan, Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 1 hour of Category I credit

* * *

DATE: July 17-18, AMA-MSMS Regional CME Program
LOCATION: Northern Michigan University Center, Marquette
SPONSOR: AMA and MSMS
FOR: All physicians
COST: $10 per credit hour
CONTACT: Herbert Auer, manager, MSMS Department of CME Programming
APPROVED FOR: 11-12 hours Category I credit

* * *

DATE: Aug. 4, 11, and 18, Significant Aspects of Athletic Injuries
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan, Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 1 hour of Category I credit

* * *

DATE: August 28-31, Current Topics in Medicine
LOCATION: Grand Hotel, Mackinac Island
SPONSOR: U-M Office of Intramural Education
COST: $150
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 11¼ hours of Category I credit

CATEGORY I/*Continued*

DATE: Sept. 1, 8 and 15, Infectious Diseases
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan, Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 1 hour of Category I credit

* * *

DATE: Sept. 2-Nov. 11 — Clinical Endocrinology and Infertility Seminars
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, 48236
SPONSOR: Saint John Hospital
FOR: Internal Medicine — OB-GYN — Family Physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 20 Hours of Category I Credit

* * *

DATE: Sept. 6-Nov. 8, Seminars in Perinatology
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, 48236
SPONSOR: Saint John Hospital
FOR: Family practice
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 20 Hours of Category I Credit

* * *

DATE: Sept. 7-Nov. 9 — Oncology Today
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, 48236
SPONSOR: Saint John Hospital
FOR: All interested physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 20 Hours of Category I Credit

* * *

DATE: September 10-11, Anesthesiology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $60
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 8½ hours of Category I credit

* * *

DATE: Sept. 22 — Allergy & Immunology Seminar
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, MI 48236
SPONSOR: Saint John Hospital
FOR: Allergy — Immunology
COST: $50
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 7 Hours of Category I Credit

* * *

DATE: Sept. 29, Infectious Disease Symposium
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 4 hours of Category I credit

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* Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**Continuing Medical Education, 1206 Scott Hall, 540 E. Canfield, Wayne State University, Detroit 48201.

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

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consider the effect on coexisting glaucoma when you prescribe a vasodilator*

a vasodilator that has not been reported to raise intraocular pressure

VASODILAN®

(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

Mead Johnson LABORATORIES

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*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

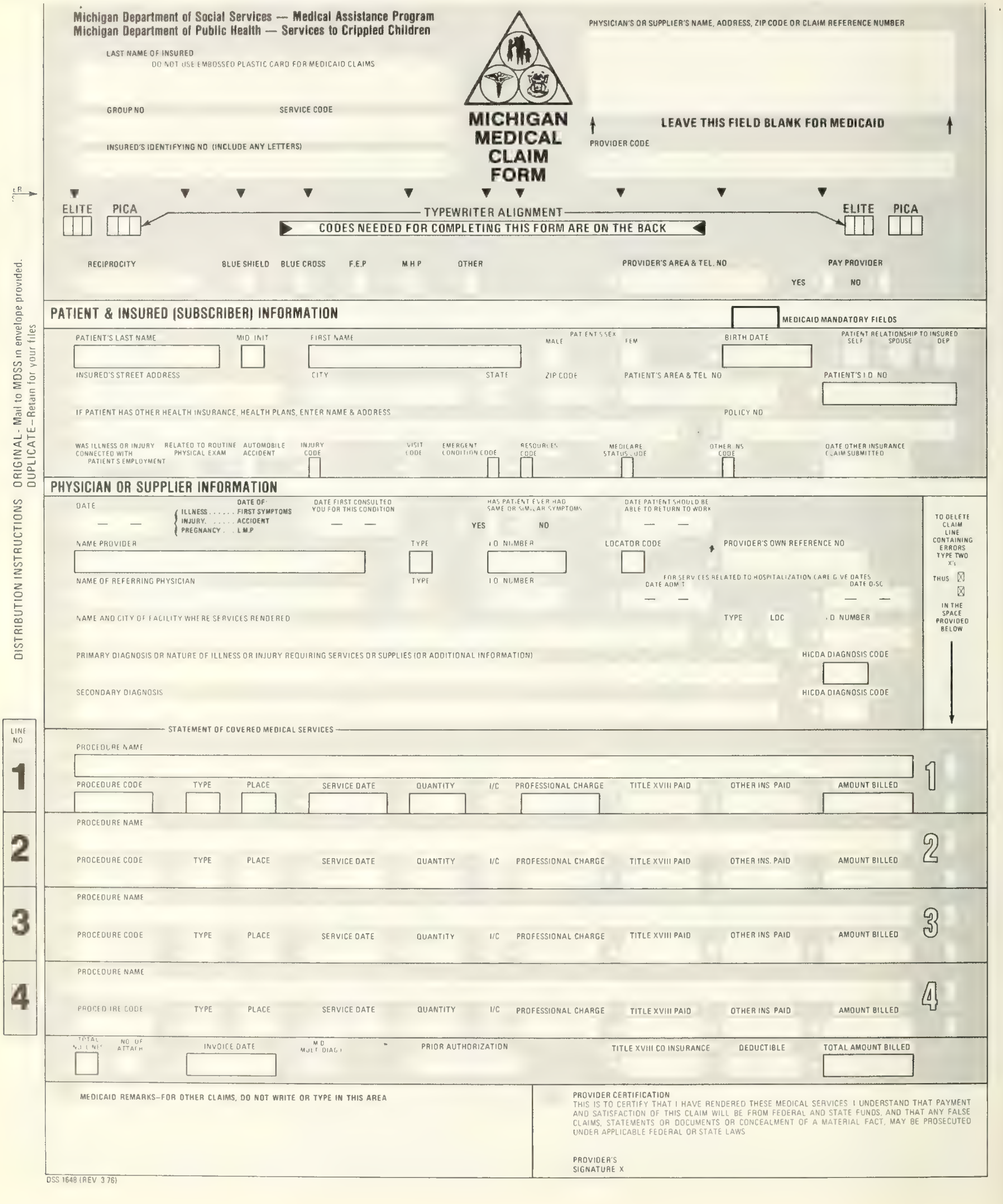
Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

On the following pages, the MDSS and BC/BS describe the differences in their versions of the form. The overall history and use of the form are described by Donald K. Crandall, MD, chairman, MSMS Negotiating Committee with Third Party Carriers.

Here, side by side for your easy comparison, are reproductions of the new Michigan Medical Claim form, to be used, *this page,* for Medicaid patients, and *opposite page,* for Michigan Blue Cross/Blue Shield insureds. The two versions are as alike as possible.



Michigan Department of Social Services — Medical Assistance Program
Michigan Department of Public Health — Services to Crippled Children

LAST NAME OF INSURED
DO NOT USE EMBOSSED PLASTIC CARD FOR MEDICAID CLAIMS

GROUP NO — SERVICE CODE

INSURED'S IDENTIFYING NO (INCLUDE ANY LETTERS)

MICHIGAN MEDICAL CLAIM FORM

PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE OR CLAIM REFERENCE NUMBER

LEAVE THIS FIELD BLANK FOR MEDICAID

PROVIDER CODE

ELITE PICA — TYPEWRITER ALIGNMENT — ELITE PICA

CODES NEEDED FOR COMPLETING THIS FORM ARE ON THE BACK

RECIPROCITY — BLUE SHIELD — BLUE CROSS — F.E.P — M.H.P — OTHER — PROVIDER'S AREA & TEL. NO — PAY PROVIDER YES NO

PATIENT & INSURED (SUBSCRIBER) INFORMATION

☐ MEDICAID MANDATORY FIELDS

PATIENT'S LAST NAME — MID INIT — FIRST NAME — PATIENT'S SEX MALE FEM — BIRTH DATE — PATIENT RELATIONSHIP TO INSURED SELF SPOUSE DEP

INSURED'S STREET ADDRESS — CITY — STATE — ZIP CODE — PATIENT'S AREA & TEL NO — PATIENT'S I D NO

IF PATIENT HAS OTHER HEALTH INSURANCE, HEALTH PLANS, ENTER NAME & ADDRESS — POLICY NO

WAS ILLNESS OR INJURY CONNECTED WITH PATIENT'S EMPLOYMENT — RELATED TO ROUTINE PHYSICAL EXAM — AUTOMOBILE ACCIDENT — INJURY CODE — VISIT CODE — EMERGENT CONDITION CODE — RESOURCES CODE — MEDICARE STATUS CODE — OTHER INS CODE — DATE OTHER INSURANCE CLAIM SUBMITTED

PHYSICIAN OR SUPPLIER INFORMATION

DATE — — { ILLNESS . . . . . . FIRST SYMPTOMS / INJURY . . . . . . ACCIDENT / PREGNANCY . . L.M.P } DATE OF — DATE FIRST CONSULTED YOU FOR THIS CONDITION — — — HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES NO — DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK — —

NAME PROVIDER — TYPE — I D NUMBER — LOCATOR CODE — PROVIDER'S OWN REFERENCE NO

NAME OF REFERRING PHYSICIAN — TYPE — I D NUMBER — FOR SERVICES RELATED TO HOSPITALIZATION CARE GIVE DATES DATE ADM'T — — DATE DISC — —

NAME AND CITY OF FACILITY WHERE SERVICES RENDERED — TYPE — LOC — I D NUMBER

PRIMARY DIAGNOSIS OR NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (OR ADDITIONAL INFORMATION) — HICDA DIAGNOSIS CODE

SECONDARY DIAGNOSIS — HICDA DIAGNOSIS CODE

TO DELETE CLAIM LINE CONTAINING ERRORS TYPE TWO X's THUS ☒ ☒ IN THE SPACE PROVIDED BELOW

STATEMENT OF COVERED MEDICAL SERVICES

LINE NO

1 PROCEDURE NAME / PROCEDURE CODE — TYPE — PLACE — SERVICE DATE — QUANTITY — I/C — PROFESSIONAL CHARGE — TITLE XVIII PAID — OTHER INS PAID — AMOUNT BILLED 1

2 PROCEDURE NAME / PROCEDURE CODE — TYPE — PLACE — SERVICE DATE — QUANTITY — I/C — PROFESSIONAL CHARGE — TITLE XVIII PAID — OTHER INS. PAID — AMOUNT BILLED 2

3 PROCEDURE NAME / PROCEDURE CODE — TYPE — PLACE — SERVICE DATE — QUANTITY — I/C — PROFESSIONAL CHARGE — TITLE XVIII PAID — OTHER INS PAID — AMOUNT BILLED 3

4 PROCEDURE NAME / PROCEDURE CODE — TYPE — PLACE — SERVICE DATE — QUANTITY — I/C — PROFESSIONAL CHARGE — TITLE XVIII PAID — OTHER INS PAID — AMOUNT BILLED 4

TOTAL NO LINES — NO OF ATTACH — INVOICE DATE — M D MULT DIAG — PRIOR AUTHORIZATION — TITLE XVIII CO INSURANCE — DEDUCTIBLE — TOTAL AMOUNT BILLED

MEDICAID REMARKS—FOR OTHER CLAIMS, DO NOT WRITE OR TYPE IN THIS AREA

PROVIDER CERTIFICATION
THIS IS TO CERTIFY THAT I HAVE RENDERED THESE MEDICAL SERVICES. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

PROVIDER'S SIGNATURE X

DSS 1648 (REV 3 76)

DISTRIBUTION INSTRUCTIONS ORIGINAL - Mail to MDSS in envelope provided. DUPLICATE – Retain for your files

LAST NAME OF INSURED FIRST NAME

GROUP NO. SERVICE CODE

INSURED'S IDENTIFYING NO. (INCLUDE ANY LETTERS)

MICHIGAN MEDICAL CLAIM FORM

PHYSICIAN OR PROVIDER NAME, ADDRESS, ZIP CODE

PROVIDER CODE

TYPE ALIGN

RECIPROCITY BLUE SHIELD ☐ BLUE CROSS ☐ F.E.P. ☐ M.H.P. ☐ COMP. ☐ OTHER ☐

PROVIDER'S AREA & TEL. NO.

PAY PROVIDER YES ☐ NO ☐

ATIENT & INSURED (SUBSCRIBER) INFORMATION

PATIENT'S LAST NAME MID. INT. FIRST NAME

2. PATIENT'S SEX MALE ☐ FEM. ☐

3. BIRTH DATE

4. PATIENT RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ DEP. ☐

INSURED'S STREET ADDRESS CITY STATE ZIP CODE

6. PATIENT'S AREA & TEL. NO.

7. PATIENT'S ACCT. NO.

IF PATIENT HAS OTHER HEALTH INSURANCE, HEALTH PLAN OR STATE ASSISTANCE, ENTER ITS NAME, ADDRESS AND ---------- POLICY OR MEDICAL ASSISTANCE NO.

WAS ILLNESS OR INJURY CONNECTED WITH PATIENT'S EMPLOYMENT ☐

10. RELATED TO ROUTINE PHYSICAL EXAM ☐

11. AUTOMOBILE ACCIDENT ☐

12. INJURY CODE ☐

13. VISIT CODE ☐

14. EMERGENT CONDITION CODE ☐

15. RESOURCES CODE ☐

16. MEDICARE STATUS CODE ☐

17. OTHER INS. CODE ☐

18. DATE OTHER INSURANCE CLAIM SUBMITTED

HYSICIAN OR PROVIDER INFORMATION

DATE
ILLNESS...... DATE OF FIRST SYMPTOMS
INJURY....... DATE OF ACCIDENT
PREGNANCY .. DATE OF L.M.P. OR E.D.C.

20. DATE FIRST CONSULTED YOU FOR THIS CONDITION

21. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES ☐ NO ☐

2. DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK

23. DATES OF PATIENTS DISABILITY (TOTAL) FROM THRU (PARTIAL) FROM THRU

NAME OF REFERRING PHYSICIAN OR PROVIDER ---------- TYPE ---------- PROVIDER CODE

25. FOR SERVICES RELATED TO HOSPITALIZATION CARE GIVE DATES
DATE ADMIT. DATE DISC.

NAME AND CITY OF FACILITY WHERE SERVICES RENDERED ---------- TYPE ---------- LOC. ---------- FACILITY CODE

7. DIAGNOSIS OR ADDITIONAL INFORMATION

V. E	A. DATE OF SERVICE	B. LOC. OF SERV.	C. SERV. TYPE	D. NABSP PROCEDURE CODE	E. **BCBSM USE ONLY**	F. CHARGES	G. HICDA DIAGNOSTIC CODE	H. I.C.	I. QUANTITY	J. MISC. DATE	K. EXPL. CODE	LEAVE BLANK
1		☐	☐			$		☐				
2		☐	☐			$		☐				
3		☐	☐			$		☐				
4		☐	☐			$		☐				
5		☐	☐			$		☐				
6		☐	☐			$		☐				

TOTAL# SERV. LI. ☐

30. NO. OF ATTACH'S ☐

31. PROVIDER SOCIAL SECURITY NO.

32. PROVIDER EMPLOYER I.D. NO.

33. TOTAL CHARGES $

34. AMOUNT PAID $

35. BALANCE DUE $

36. MULT. DIAG. ☐

INSURED'S (SUBSCRIBER'S) CERTIFICATION

BLUE CROSS AND BLUE SHIELD MEMBER PLEASE READ CAREFULLY

PLEASE REFER TO THE "PAY PROVIDER" AREA INDICATED ON THE TOP OF THIS CLAIM FORM.
IF THE "YES" BLOCK IS CHECKED, PAYMENT WILL BE SENT TO THE DOCTOR/PROVIDER. YOUR SIGNATURE IS NOT NECESSARY.
IF THE "NO" BLOCK IS CHECKED, PAYMENT WILL BE SENT TO THE SUBSCRIBER.
YOUR SIGNATURE IS NOT REQUIRED TO RECEIVE BLUE CROSS AND BLUE SHIELD OF MICHIGAN BENEFITS. THE CONTRACTUAL PROVISIONS CONCERNING PAYMENT OF BENEFITS EXPLAIN YOUR RIGHTS AND OBLIGATIONS. THIS IS REPRODUCED ON THE REVERSE SIDE OF THIS FORM. YOUR SIGNATURE IS REQUIRED ONLY IF YOU AGREE TO THE CERTIFICATION STATEMENT BELOW WHICH MAY OBLIGATE YOU TO MAKE AN ADDITIONAL PAYMENT FOR SERVICES:
"I UNDERSTAND THE PROVIDER'S CHARGE MAY EXCEED THE BLUE CROSS AND BLUE SHIELD OF MICHIGAN PAYMENT, AND IF GREATER THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THAT AMOUNT."

O NOT WRITE OR TYPE IN THIS AREA—CLAIM REFERENCE NO.

INSURED'S OR SUBSCRIBER'S OPTIONAL SIGNATURE DATE

PROVIDER'S CERTIFICATION **(READ BACK BEFORE SIGNING)** DATE

87-2 JUL. 76

The Michigan Medical Claim Form — its background and how to use it

By Donald K. Crandall, MD, Chairman MSMS Negotiating Committee

After almost two years' work by the MSMS Negotiating Committee with Third Party Carriers, Blue Cross and Blue Shield of Michigan, the Michigan Department of Social Services and Michigan's independent insurance carriers, a standardized claims form and standardized coding system will become a reality July 1, 1976.

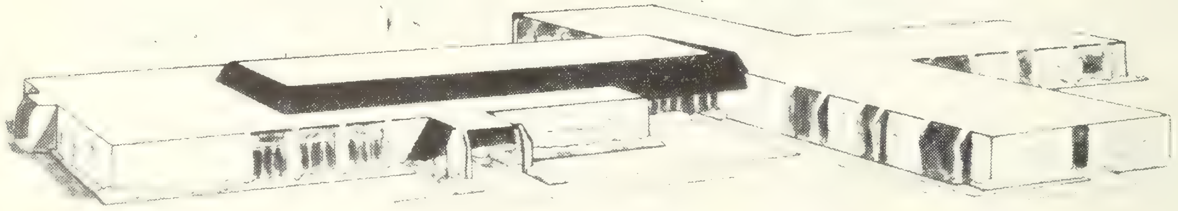
Basically, there is one form with a few alterations for Medicaid patients who are reimbursed by the DSS. There is no new data required. Rather, the new form combines and standardizes the placement of the data elements. The forms will be color coded to easily identify each reimbursement program. Essentially, this means that all forms submitted to BC/BS, Medicare-Part B (when final approval is granted), and to the independent insurers will be the same but for color, while the last third of the MDSS form will be slightly different. The accompanying article and reproduction of the MDSS form will help to explain how it differs from the other forms.

As mentioned in the accompanying article by BC/BS, the Medicare form has not received final approval by SSA. The request for approval has been made and a favorable reply is expected in the near future. Until that time it will be necessary to continue to file claims for federal programs on the old form.

At the present time the Health Insurance Institute of America, which represents all independent insurers in Michigan, has committed itself to the AMA model uniform claims form and cannot in good conscience lend its endorsement to the Michigan form. The Institute sees no difficulty in processing the forms and will accept them for processing. Final details have not been worked out as to how the forms for the private companies will be distributed, but this information will be made available before the July 1 implementation date.

The important thing to remember about the new form is that in almost

FOREST VIEW PSYCHIATRIC HOSPITAL



Charles L. Callaway MD, Medical Director

Located on six beautifully wooded acres, *FOREST VIEW HOSPITAL* is Michigan's newest private psychiatric facility, specializing in short term intensive treatment. Comprehensive adjunctive therapy, including occupational and recreational therapy is emphasized. The prime goal of the hospital personnel is to aid the patient in coping with his illness and return him to community life as soon as possible. Licensed by the State of Michigan, Department of Mental Health, Accredited by the Joint Commission of Accredation of Hospitals, Participant in Medicare and Medicaid.

Full Blue Cross participation.

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Grand Rapids, Michigan 49506
Michael H. Payne, Administrator
616-942-9610

all cases the same data requirements are in the same place on each form. It will not be necessary to fill in all the boxes every time, and a system of shading and outlining will be used to designate which boxes are needed for which carrier. Another important factor is that most of the boxes on the forms line up vertically. This means that one setting can be made on the typewriter and it will line up with all the boxes no matter which carrier is being billed.

Another major advantage of the forms is that they can be optically read. This means that processing time will be decreased.

The coding system basically will follow the current National Association of Blue Shield Plans (NABSP) codes, used by both BC/BS and MDSS. The only additions in the new coding system will be for procedures for which there was not a prior designation in any one of the previous coding systems. The place and type-of-service designator codes will be as shown on the back of the MDSS form printed with this article. They basically repeat the BC/BS coding system

(Continued on page 334)

The new form – from BC/BS point of view

The use of the Michigan Medical Claim Form and the revised system of procedure codes will be effective July 1, 1976 for all Blue Cross and Blue Shield of Michigan professional billings with the exception of Medicare Part B, Champus, Dental and Drugs. A proposal has been presented to the Social Security Administration requesting that the Michigan Medical Claim form and the revised procedure coding system be adopted for use in Medicare claim submissions. Work is underway now to get final approval of the form for use in the above programs. However, until further notice, these changes will not be applicable to these programs.

The Michigan Medical Claim Form does incorporate the necessary elements required by Blue Cross and Blue Shield of Michigan and the Michigan Department of Social Services. However, as requirements of Blue Cross and Blue Shield of Michigan and the Department of Social Services will remain essentially unchanged with implementation of the new claim form, the unique specifications of each carrier are such that billing instructions will not be identical.

Blue Cross and Blue Shield of Michigan will continue to distribute their individualized billing instructions accompanied by the allotment of claims, to physicians prior to the July 1, 1976 implementation date. Then a new procedural coding manual containing revised codes and their nomenclatures, specifically designed to meet the requirements of the new form, will be distributed by BC/BS and the Bureau of Medical Assistance.

A series of medical assistants' seminars, which will focus on the proper completion of the Michigan Medical Claim form, and use of the revised system of procedure coding for the Michigan Medical Claim Form, will be conducted beginning May 21, 1976. Those providers and medical assistants interested in gaining a thorough knowledge of these changes prior to the July 1, 1976 implementation date are advised to contact the Blue Cross and Blue Shield of Michigan district office in their locality.

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600091

MICHIGAN MEDICAL CLAIM FORM/*Continued*

with a few additions. Again, as with the form, the new coding system has not yet received the authorization of Medicare Part B, and CHAMPUS, and physicians must continue to use the old codes for these systems until final approval is received.

An extensive procedure has been agreed upon for approval of any new code. Basically, the NABSP, an individual physician, specialty society or an internal processing request can initiate a suggestion for a new code. The request will then go to a uniform procedure code coordinator at Blue Cross/Blue Shield of Michigan and then to a joint committee of BC/BS of Michigan and the MDSS. The request will proceed to the MSMS Negotiating Committee and if it is decided that a new code is needed, it returns to the BC/BS code coordinator for processing and communication to the providers. This system will allow for a comprehensive review of the need for a new code as well as input from any interested party.

As in any major change, there may be a few problems. To keep them to a minimum both BC/BS and MDSS have started an extensive education program to help explain the form and coding system.

The accompanying article and reproduction of the MDSS form will help to acquaint the physician with the new form and the procedure that will be followed in introducing it. The Negotiating Committee is continuing to meet with the Blues and MDSS and any other interested parties to discuss any problems that may emerge. As the Committee gains information of the forms and any problems that may exist, it will continue to suggest further refinements to make it easier for the physician's office staff.

It is strongly suggested that the physician try to attend the educational seminars sponsored by MDSS or the Blues to familiarize her/himself with the new coding system and form. Additional educational material will be sent out to physicians' offices by the third party carriers and will also help in the transition to the new forms and coding system.

A great deal of effort and time has gone into the development of the form and it is hoped that the spirit of cooperation will continue with the third party carriers in the future.

All of the parties involved in the development of the form stand ready to help in any way possible if physicians have difficulty or questions regarding the form.

(Physicians with questions may contact John Richards at MSMS Headquarters.)

The new form – from DSS point of view

The Medicaid "Michigan Medical Claim Form" differs from the BC/BS Claim form in the following way — the Medicaid form has:

1. A single, common left margin for all lines, from top to bottom to include the patient, physician, and service/payment areas. Typewriter alignment boxes and 10 tab stops satisfy all required fields.
2. Mandatory fields required for Medicaid payment bordered with dark red lines.
3. Enrollment identification in boxes 47 to 50 preprinted for providers.
4. Little required demographic information about the recipient.
5. No requirement for the patients' signature.
6. An identifier box for the doctor's own reference and use, e.g., case reference, patient number.
7. A claim line "error delete" feature so an incorrect claim line will be overlooked by the computer, rather than requiring the complete re-typing of the form.
8. All fields on the Medicaid form clearly labeled.
9. Certain codes necessary for invoice completion printed head to foot on the back of the form for easy reference during typing.
10. Procedure, type and place codes located (zoned) together.
11. A space designated specifically for remarks to relate to the individual consideration (I/C) and specifics of the claim form.

Opposite page→

Reproduction of the new type-of-service and place-of-service coding system to be used with the new Michigan Medical Claim Form.

BOX NUMBER	CODE NAME	CODE
35	Injury Code (Accident/ Occupational Injury Code)	1 = Not an accident 2 = Accident other than work or auto related 3 = Referral from an EPSDT screening 4 = Work related accident 5 = Auto related accident
37	Emergent Condition Code	1 = Emergency 2 = Non-emergency
38	Resources Code	1 = No other Health Insurance 2 = Private Insurance 3 = Blue Cross/Blue Shield 4 = Employer/Union 5 = Workmen's Comp. 6 = Eligible for Medicare 7 = DSCC (Division of Services to Crippled Children), 8 = Other
39	Medicare Status Code	1 = Under age 65, does not have Medicare 3 = Patient 65, not eligible 5 = Medicare payment made 6 = Service not covered by Title XVIII 7 = Deductible not satisfied.
40	Other Insurance Status Code	1 = Not a policyholder 2 = Benefits exhausted/expired 5 = Other insurance payment made 6 = Service not covered 7 = Claim in process.

BOX NUMBER	CODE NAME	CODE	
67, 78, 89, & 100	Type of Service Code	Anesthesia	4
		Consultation	9
		Maternity	3
		Medical Care	6
		Pathology	8
		Physical Therapy/Medicine, or Manipulative Therapy	D
		Professional Component	P
		Psychiatric Care	C
		Pulmonary Tuberculosis	N
		Radioimmunoassay	T
		Surgery	2
		Surgical Assistance (Numeric)	0
		X-ray Diagnostic	5
		X-ray Therapeutic	E

BOX NUMBER	CODE NAME	CODE	
68, 79 90, & 101	Place of Service Code	Inpatient Hospital	1
		Outpatient Hospital	2
		Office	3
		Home	4
		Domiciliary or Intermediate Care Facility	7
		Extended Care or Skilled Nursing Facility	8
		Independent Lab	A
		Other Medical/Surgical Facility (Non Psychiatric)	B
		Residence Substance Abuse	D
		Outpatient Substance Abuse	E

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Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the Four-Week Period Ending April 30, 1976

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1976 This 4-Week Period	1975 Same 4-Week Period	1976 Total To Above Date	1975 Total Same Date	Total Cases for 1975
Rubella	202	234	756	802	1,975
Cong. Rubella Syndrome	0	0	0	1	1
Measles	1,143	442	2,538	1,601	3,253
Whooping Cough	2	7	27	33	98
Diphtheria	0	0	0	1	1
Mumps	955	1,427	3,708	5,469	9,979
Scarlet Fever & Strep Sore Throat	1,982	2,059	10,399	10,706	23,777
Tetanus	0	0	0	0	0
Poliomyelitis (paralytic)	1	0	1	0	0
Hepatitis	201	200	825	961	2,877
Salmonellosis (other than S. typhi)	42	42	242	267	864
Typhoid Fever (S. typhi)	0	0	1	1	10
Shigellosis	57	48	179	268	745
Aseptic Meningitis	11	5	36	26	280
Encephalitis	5	5	29	23	168
Meningococcic Meningitis	5	10	32	42	76
H. Influenza Meningitis	10	10	46	43	142
Tuberculosis	117	114	443	349*	1,220
Syphilis	90	142	388	559*	1,614
Gonorrhea	2,376	2,100	10,400	9,828	32,472

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

*corrected totals

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The situation is critical at Detroit General

By Charles Reece

Special to Michigan Medicine

Detroit General Hospital has reached a critical time in its long history, according to L. Murray Thomas, MD, president of the hospital's medical staff and associate dean of Wayne State University's School of Medicine, and Alexander Walt, MD, chairman of surgery at the University's School of Medicine and chief of surgery at Detroit General and Harper hospitals.

A new structure to house the hospital is being erected in Detroit Medical Center, and detailed plans have been compiled, aimed at making DGH a viable, competitive hospital there.

However, the dean of Wayne State University's Medical School, Robert D. Coye, MD, along with Doctors Thomas and Walt are firmly convinced that DGH will not be able to regain its status as a truly first-class hospital unless necessary changes are made in the way the hospital is operated.

"As it is today, the hospital is not responsive to modern health-care needs," Doctor Walt states. "The staff feels frustrated and unable to produce adequately for the patients.

Doctor Thomas adds that, "the only reasons many members of the staff stay there now are because of their dedication to the care of the ill, their belief that DGH still offers an opportunity to train physicians, their concern for trauma, their (fading) hope that things will change when the hospital moves to the Medical Center, and their long-time loyalty to DGH.

"All of these reasons have been eroded over the years as we received promises that changes would be made — but none materialized.

"No one believes the promises any more. Perhaps more serious than that, are the facts that now there are many other hospitals in which Wayne State University can train students, there are other places with many trauma cases, and where one can treat the indigent. A person's loyalty to a withering institution can last only so long, especially when one knows that patients are not receiving the level of care to which they are entitled."

DGH Just Another Part Of City Government

The basic problem, as these men see it (not taking into consideration that the hospital's accreditation was withdrawn by the Joint Commission on Accreditation of Hospitals, but is now under review) is that the hospital is run as just another part of city government with little attention given to the elements which make a hospital a special type of institution, with certain specific needs peculiar only to such a facility.

All purchases for DGH, all hiring and administrative decisions must go through a long, bureaucratic process in the City of Detroit's chain of command.

"The same people who make purchases for the Fire Department and zoos, make decisions on how much medicine DGH will have. When budgets must be cut, DGH's budget is slashed by people who have no real understanding of where a hospital might best be able to tighten its belt while still providing dependable health care, according to Doctor Thomas.

"We have run out of certain supplies repeatedly, which for the most part, presented few insurmountable conditions. But we have also been completely without antibiotics at times."

Dean Coye remarks that, "Until about 10 years ago, Wayne State University's medical school was dependent upon DGH. If something had happened to close the hospital in those days, we could have managed someway, of course, but it would not have been easy.

"Today, that has changed. With only about 25% of our clinical teaching at Detroit General, we could continue quite well if it were no longer available to us.

"We would not like for that situation to develop, but it could well do so within the foreseeable future.

"Unless DGH is reorganized as a public benefit corporation, as Detroit's voters have said it could be, with a board of trustees — accountable to the city, but with the freedom and ability to operate the hospital in an improved manner — and unless the hospital becomes fully accredited again, the medical school will have no choice but to seriously consider discontinuing its association with Detroit General.

"Let me reiterate," the Dean insists, "the University wants to work with Detroit General and Detroit Medical Center to raise the level of care to where it should be for all members of the community.

"If Detroit General can be made to function as a contributing member of the Medical Center, it will offer an unusual opportunity to solve some of the health needs of this area in the most economical way possible. That is, with all of the Center's hospitals doing primarily what they do best."

No Public Benefit Corporation Yet

In the late 1960's citizens of Detroit recognized that DGH was not the hospital it should be and voted for a "Proposition B" which stated, in

DGH CRITICAL/*Continued*

part, that the mayor could place DGH under the guidance of a Public Benefit Corporation.

This has not been done.

"So the hospital has continued deteriorating under a board, which I believe is dedicated to it and to the best care possible for its patients, but which is relatively impotent because its actions are totally dependent on the City of Detroit," Doctor Walt continues.

"Today, Detroit General is cramped, sometimes dirty, always under-staffed and under-equipped . . . a place where no member of the City Council chooses to go for medical treatment."

Doctor Walt agrees with Dean Coye and Doctor Thomas that it is essential that DGH be operated as a Public Benefit Corporation with members of its board chosen from people who now use the hospital, as well as persons who are experts in finance, administration, medicine, and other professions which could contribute.

As they view it, the board should be sensitive to the needs of a modern hospital and have the ability to react rapidly to those needs. It should demand decent physical facilities for patients, adequate nursing, adequate laboratory, radiological, and other services, and it should provide competitive salaries for the entire staff. It should make sure that the hospital is administered professionally and efficiently, and have control of a budget that takes into account what is necessary to meet today's medical standards.

"This would not insure that Detroit General Hospital would become what it can and should be, but it would give the hospital a chance to do so," Dean Coye emphasizes.

Detroit General Not a Complete General

Doctor Walt suggests that there should be some form of medical insurance for patients with no money, and that this should make medical care available, to all patients, at whatever Detroit Medical Center hospital is best equipped to care for their immediate needs.

"For instance," he says, "if the best place to treat a special neurological condition is Harper Hospital, then the patient should be able to go to Harper.

"Under the city's present requirements, all patients who cannot pay for their hospital stay must go to Detroit General, no matter how inadequate DGH is in that particular specialty.

"Detroit General is not a complete general hospital now, and has not been for some time. It has no pediatrics, and no obstetrics departments. It is an emergency hospital, geared to treat serious trauma."

While the accreditation question will not be settled for months, there is reason to believe that DGH can regain its accreditation if steps are placed in action to correct its deficiencies.

Will these necessary steps be taken?

Will the City of Detroit's leaders move to help make DGH a full member of Detroit Medical Center, capable of carrying its own weight?

If so, Dean Coye and Doctors Thomas and Walt see a future for Detroit General.

If not, the conditions which make this a critical time for the institution could well culminate in disaster for what once was one of North America's outstanding general hospitals.

State Civil Service boost pay to recruit physicians

By Kenneth Hintz, Lansing Special to Michigan Medicine

Physicians, especially psychiatrists, are being sought to join the many State of Michigan programs that are operating with funded vacancies because they don't have candidates to fill those positions. The Department of Mental Health alone has 20 such vacancies in its agencies. Other vacancies for physicians exist in state correctional facilities, schools for the deaf and schools for the blind throughout the state.

Leading the search is the Recruitment section of the Michigan Department of Civil Service.

The Michigan Civil Service Recruitment Task Force is addressing the problem, as well as many others, but there can only be recommendations made to the Civil Service Commissioners as to the keys to the solutions of the recruitment problems.

The solutions themselves lie with the people, and specifically with Michigan physicians, and whether or not they channel their services into the state agencies.

The Task Force has attempted to analyze the inability of state services to attract an adequate number of qualified medical personnel to its programs. The committee is looking at isolated factors contributing to this situation.

An evident major factor in recruitment of physicians is the salary disparity between state service and private practice.

The market for physicians, especially psychiatrists, in the United States continues to be very competitive and the salaries provided for state service can never quite compete with those available in private prac-

(Continued on page 343)

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1. Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976.

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meetings

(See also listing of Category I programs on page 327)

June 11-13 — Kidney Foundation of Michigan's 15th Annual Medical Symposium, Hyatt Regency Hotel, Dearborn, contact: Gerald A. Rigg, MD, Wayne County General Hospital, Eloise, Michigan

June 15-18 — Symposium on Childhood Deafness, sponsored by Central Michigan University, at CMU, contact: Lynn Kindel, Off-Campus Education, CMU, Mt. Pleasant 48859

June 17-19 — Annual Keyport Trauma Symposium, sponsored by the Michigan Committee of the American College of Surgeons, at Otsego Ski Club, Gaylord, Michigan, contact: B. E. Henig, MD, 308 Michigan Avenue, Grayling 49738

June 24-25 — Professional Health Practices and Their Impact on Aging, sponsored by Michigan Office of Services to the Aging, co-sponsored by MSMS, at Lansing Hilton Inn, contact: Paulette Whan, 3500 North Logan, Lansing 48913

June 25 — Annual meeting, American Lung Association of Southeastern Michigan, "Legislative and Administrative Aspects of Occupational Health," at Mercy College Conference Center, Detroit, contact: Frank A. Buttler, ALASEM, 28 W. Adams St., Detroit, 48226

June 26-July 1 — AMA Annual Convention, Dallas

July 11-16 — Short Course, "Community Relations for Health Services Administration," sponsored by University of Michigan School of Public Health**

July 17 — The MSMS Council, Sugar Loaf Village, Cedar, contact: Warren Tryloff

July 25-27 — Bi-Annual Meeting of the Michigan Academy of Plastic Surgeons, at Grand Hotel, Mackinac Island, contact: David B. Hawtof, MD, 15901 West Nine Mile Rd., Southfield 48075

July 25-30 — Short Course, "Supervision of the Health Field: Theory, Process, Practice," sponsored by University of Michigan School of Public Health**

July 29-30 — Coller-Penberthy-Thirlby Medical Conference at Park Place Motor Inn, Traverse City, contact: Laurence P. Skendzel, MD, Munson Medical Center, Traverse City 49684

July 31-Aug 4 — Annual Meeting and Scientific Assembly, Michigan Academy of Family Physicians, Holiday Inn, Traverse City, contact: Rita Feldkamp, Exec. Sec., 933 Wing St., Plymouth 48170

August 8-13 — Short Course, "Problems in Planning and Evaluation," sponsored by University of Michigan School of Public Health**

September 1 – The Council, MSMS headquarters, contact: Warren Tryloff, director

September 18 — September Seminar, "Lesions of the Bone," Michigan Society of Pathologists, St. John Hospital, Detroit, contact: Robert Hendrix, Dept. of Pathology, University of Michigan, Ann Arbor 48109

October 6-9 — Convention, American Medical Writers' Association, Pontchartrain Hotel, Detroit, contact: Lillian Sablack, Executive Director, AMWA, 9650 Rockville Plaza, Bethesda, MD, 20014

**Contact: Dr. Anna B. Brown, Director of Continuing Education, 3550 School of Public Health I, the University of Michigan, 109 S. Observatory Street, Ann Arbor, MI 48109

CIVIL SERVICE/*Continued*

tices. However, the state has tried to alleviate this problem by authorizing a salary base increase, for fiscal year 1977, to take up some of the slack.

The new base pay scale for fiscal year 1977, effective July 1, 1976, is:

Class 14 . . . $24,847 — $30,109
Class 15 . . . $26,956 — $32,594
Class 16 . . . $28,752 — $34,911
Class 17 . . . $30,631 — $37,250
Class 18 . . . $32,218 — $39,588
Class 19 . . . $33,805 — $41,823
Class 21 . . . $36,811 — $44,516

Physicians with a license to practice medicine or osteopathic medicine and no experience can generally expect to enter at the class 14 level. Those physicians with two years of experience in the practice of medicine usually start at class 15. Psychiatrists with a license and three years of residency training in the specialty usually start at class 16 and those with more training or experience can expect to start at a higher level. Class 21 is usually reserved for medical superintendents.

This new scale, the opportunity to work at prestigious hospitals throughout the state, such as the world-renowned Lafayette Clinic, good working hours and the opportunity to practice without a high capital investment in facilities or staff make state service more attractive.

The Department of Civil Service does accept appointments for examinations to these positions daily. Interested physicians should contact the Recruitment Section of the Michigan Civil Service Commission, third floor, Lewis Cass Building, Lansing, for further details.

The Task Force was conceived to review recruitment and career counseling functions of the Civil Service Department and to aid in the building of a more comprehensive program. Its 10 experts bring together knowledge and experience from the fields of health, education, law and administrative services.

Members representing the health field are Herbert Auer, manager, Department of Communications, MSMS; and John Doherty, executive vice-president, Michigan Health Council.

Maternal Health Conference draws crowd of MDs, nurses

James V. Neel, MD, Ann Arbor, a conference speaker, was interviewed by WKZO-TV reporter Ed Welch, Kalamazoo. Doctor Neel's topic was genetic risks and their counseling.

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FIAC

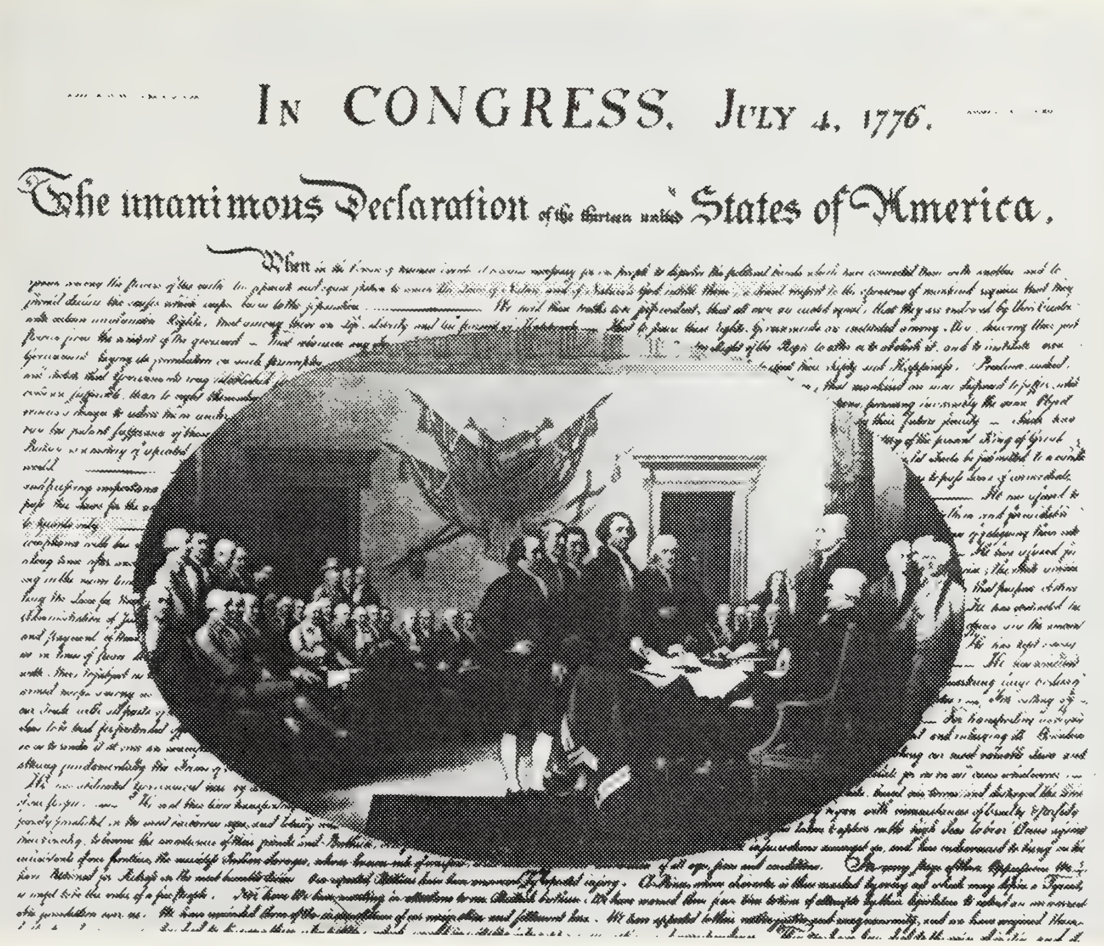
The 1976 Michigan Conference on Maternal and Perinatal Health, sponsored largely by MSMS, drew nearly 900 people to the Kalamazoo Center Inn. Among the physicians having their CME records stamped were, left, Van O. Keeler, MD, Otsego; and right, Martin Kleiman, MD, Battle Creek. Physician in center is unidentified.

There was much interest in the discussion of the family's response to abnormalities in the newborn and the professional's role in helping the family cope with those abnormalities. Leading the discussion were D. W. Hoffman, ThM, Grand Rapids, right, and Mrs. Dorothy Wiersma, RN, Grand Rapids.

Correction

Norma (Mrs. Robert J.) Westerhoff, Grand Rapids, was incorrectly identified in a photo feature in the May issue of Michigan Medicine as legislative chairman of the MSMS Auxiliary. Mrs. Westerhoff, former legislative chairman, was a speaker at the Auxiliary's Legislative Day. Current Auxiliary legislative chairman is E. B. (Mrs. Philip) Lange of Lansing.

Birth Certificate.



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Michigan doctors, families meet their congressmen in Washington

Why do Michigan physicians and MSMS staff members travel all the way to Washington to meet with their congressmen once a year? The benefits of the face-to-face meetings of the annual Congressional Reception are obvious in these photos taken recently of the Michigan delegation and their own Michigan congressmen at the Capitol Hill Club, Washington. The goodwill, close contact, exchange of greetings and ideas make the trip worthwhile. And the educational experience of the AMA-AMPAC Congressional Workshop preceding the reception doubles the value of the weekend experience.

MSMS Council Chairman Ernest P. Griffin, Jr., MD, Flint, left, and Mrs. Griffin meet Sen. Robert Griffin of Traverse City.

From left, MSMS Immediate Past President Brock E. Brush, MD, Detroit; Rep. Bob Carr (Lansing) and Margaret Jones, MD, East Lansing.

The Berglunds – Tracy, left; Thomas, MD; Jill and Tom, of Kalamazoo, meet their congressman, Garry Brown, second from left.

From left, Warren F. Tryloff, MSMS director, and Rep. Charles Diggs, Detroit.

In Memoriam

Warren W. Babcock, MD
Ft. Lauderdale

Former Wayne County Medical Society president and MSMS Councilor Warren Wood Babcock, MD, died March 10 at the age of 78. Doctor Babcock had been residing in Fort Lauderdale. A surgeon, he was a graduate of the University of Michigan Medical School and former chief of staff of the Grace Hospital, Detroit. He was a founder and past member of the executive council, member of the Detroit Surgical Society, past president of the Detroit Academy of Surgery, and past president of the Interprofessional Council of Detroit. He was also a fellow and former vice regent of the International College of Surgeons.

John D. Boehm, MD
West Branch

John David Boehm, MD, retired West Branch physician, died Feb. 29 at the age of 87. Doctor Boehm was a graduate of St. Louis University medical school and had been affiliated with Tolfree Memorial Hospital, West Branch. He formerly had practiced in Ingham and Wayne counties.

William L. Brosius, MD
Riverton, Wyoming

Former Detroit pathologist William Lewis Brosius, MD, died April 3 at the age of 77. Doctor Brosius had been residing in Riverton, Wyoming. He was past president of the Michigan Society of Pathologists and had been a delegate to the MSMS House from Wayne County Medical Society. He was a member of the College of American Pathology, American Society of Clinical Pathology, Society of American Bacteriologists, American Trudeau Society and Society for the Study of Internal Secretions.

Samuel C. Capps, MD
Grand Rapids

Samuel Carter Capps, MD, Grand Rapids pathologist, died April 24 at the age of 53. Doctor Capps was affiliated with Butterworth Hospital and was a member of the College of American Pathologists, American Society of Clinical Pathology and Michigan Pathological Society. He was a graduate of Harvard Medical School.

Henry C. Galantowicz, MD
Detroit

Long-time Detroit family physician Henry G. Galantowicz, MD, died April 6 at the age of 77. Doctor Galantowicz had been affiliated with Hutzel and The Grace hospitals and was a member of the American Academy of Family Physicians. He was a graduate of the University of Buffalo medical school.

Frank B. Gerls, MD
Pontiac

Past president of the Oakland County Medical Society, Frank Browning Gerls, MD, died March 8 at the age of 87. Doctor Gerls was a pediatrician and graduate of the University of Michigan Medical School. He was a member of the Detroit Pediatric Society and affiliated with Pontiac General Hospital.

Arthur H. Joistad, Jr., MD
Muskegon

Arthur H. Joistad, Jr., MD, Muskegon-area radiologist, died Feb. 19 at the age of 64. Doctor Joistad was affiliated with Hackley Hospital, Muskegon; Shelby Community Hospital and Oceana Hospital, Hart. He was a graduate of Duke University medical school and belonged to the American College of Radiology, Radiological Society of North America, and the American Roentgen Ray and Radium Society.

George T. Kelleher, MD
Battle Creek

Battle Creek surgeon and civic leader George T. Kelleher, MD, died April 14 at the age of 60. He was a graduate of Loyola University's Stritch College of Medicine and was affiliated with Leila Y. Post Montgomery and Community hospitals of Battle Creek, and also the Battle Creek Sanitarium. He was former Calhoun County Medical Society delegate to the MSMS House and was a fellow of the American College of Surgeons. Doctor Kelleher was active in Battle Creek city planning groups, local health care planning, area hospital planning and the Michigan Association of Regional Medical Programs. He was a fellow of the American College of Surgeons and was a member of the American Society of Abdominal Surgeons.

Harold M. Pritchard, MD
Boca Raton, Fla.

Long-time Niles family physician Harold M. Pritchard, MD, died April 3 at the age of 66. Doctor Pritchard had resided in Boca Raton since his retirement in 1975. Doctor Pritchard was a graduate of Marquette University medical school and of the Notre Dame Law School. He was on the American Board of Legal Medicine and taught courses in medical hypnosis in England, Hawaii and Japan. Doctor Pritchard was affiliated with Pawating Hospital, Niles, and Bronson Methodist Hospital, Kalamazoo.

Bella M. Rabinovitch, MD
Detroit

Detroit psychiatrist Bella M. Rabinovitch, MD, died March 30 at the age of 69. Doctor Rabinovitch was a graduate of Wayne State University School of Medicine and was affiliated with Wayne County General and Sinai hospitals of Detroit. She was a member of the Michigan Psychiatric Society.

Israel Z. Silvarman, MD
Detroit

Detroit-area family physician for 50 years, Israel Z. Silvarman, MD, died April 15 at the age of 75. Doctor Silvarman founded North Detroit General Hospital and had served as its coordinator since his retirement in 1974.

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INTERNIST, Primary physician, desires position. Experience in Emergency Medicine, Administration, Industrial Medicine, Institutional Medicine and Civil Service. Will accept position requiring travelling. Reply Box #7, 120 W. Saginaw Street, East Lansing, Michigan 48823.

OB-GYN, Internist, Family Practitioners wanted to join an expanding multispecialty group in Southwestern Michigan. Clinic located next to 89 bed general hospital, with excellent staff and equipment, to provide high quality medical care. All members of group are board certified or eligible. Excellent fringe benefits and starting salary. Write or Call: Gary Piippo, Administrator, Allegan Medical Clinic, PC, 551 Linn Street, Allegan, Michigan 49010. Phone (616) 673-8402.

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DOCTOR: Are you completing your residency or internship with no definite plans? Our group has openings for General Practitioners and all Specialties. For information, please contact Steve Sell, collect (313) 331-5110 or evenings (313) 563-1136.

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POTPOURRI

By Herbert A. Auer, Executive Editor

"We do not want in America the British-style National Health Service with all of its dreams crumbled by the thumbs of bureaucracy, all of its medical and financial chaos, all of its logjams, all of its demoralization of physicians and patients alike," so declared AMA President Max H. Parrott, MD, who trained at the U-M, in his address to the Federation of State Medical Boards.

* * *

A doctor 200 years ago depended upon his garden for some help . . . for instance, peony roots purportedly cured epilepsy, parsley helped dropsy, periwinkle eased toothaches.

* * *

Further declines in deaths from heart disease, strokes and accidents were responsible for the lowest death rate in U.S. history in 1974. The National Center for Health Statistics reports the death rate in 1974 was 9.2 per 1,000 population. This was attained despite the highest figures ever for suicide and homicide.

* * *

People, according to a new Harris poll, continue to view physicians more favorably than all other sources of their health care. Medical specialists were viewed favorably by 83% of the public poll and family physicians rated 81% favorable response, up from their 72% score in 1968.

Bicentennial slogan for the month; "Stand fast, stand tall, stand America."

* * *

"It is no longer sufficient to meet and discuss questions of science only, there are many other matters pertaining to ethical, social and business principles to be considered and wisely disposed of, if the profession of medicine is to hold a commanding position in the present scheme of affairs," so said the MSMS president, C. C. Clancy, MD, 51 years ago in 1925.

* * *

Proof that doctors are retiring earlier . . . the American Retired Physicians Association has eliminated its minimum age of 55 so younger members can be accepted.

* * *

Did you know that the first AMA-approved residency in industrial medicine in the U.S.A. was at the Saginaw County Hospital in 1949?

* * *

Doctor, do you have a library card? Are you a regular library visitor? A recent national survey found 35% of Americans have a card and 40% have been in a library last year. The average library user drops in about six times a year.

* * *

Did you know that hospital admissions in the USA in 1975 dropped for the first time in 15 years? The total was down 0.4%.

* * *

"Membership in associations is increasing largely because of increasing and more complex government relations," according to a recent article in *Wall Street Journal*. The *Journal* reports that association dues are higher; and that "associations play a bigger role in solving members' problems."

* * *

The Health Insurance Institute, NYC, estimates that the tab for defensive medicine is now between \$3 and \$5 billion annually.

* * *

You're right, the government prints a whale of a lot of forms to fill in. The federal agencies alone spent \$40 billion on forms, applications and reports. The Commission on Federal Paperwork is analyzing the problem — and generating more printed reports to tell what it is finding.

* * *

"Physicians should, even must, become more involved in our educational process, particularly at the high school level. We in the medical profession have the knowledge and experience that our teenagers desperately want and need. They are plagued with problems of drugs, sex, venereal disease, tobacco, alcohol and all the other painful and awkward problems of 'growing up.' And how we could help!" So declared Gilbert M. Wilhelmus, MD, president of the Indiana State Medical Association, recently to the Indiana House of Delegates.

* * *

When you answer a questionnaire and check the box "I don't know" or "no opinion," you are more apt to be a female than a male and more apt to be unmarried than married, according to a recent research paper in Public Opinion Quarterly.

MICHIGAN MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 7 JULY 1976

INVOLVEMENT

'76

INVOLVEMENT

is what this issue is all about.

See pages 375-386 inside for a special section on how Michigan physicians can become more involved in politics and how the MSMS is already involved for physicians. Other political essays, anecdotes and articles appear throughout the issue.

Your involvement could be the finest salute possile to this country's 200th birthday. *Michigan Medine* urges it in the name of celebration.

appy Birthday, USA!

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Predominant psychoneurotic anxiety

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

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anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

Michigan Medicine, Volume 75, Number 7, July 1976

In observance of our nation's bicentennial, this *Michigan Medicine* encourages MSMS members to take an active part in our democratic processes. Throughout the issue, from President's page to Potpourri, doctors will find articles helping them understand and participate in U.S. politics. A special section, pages 375-386, is devoted entirely to the subject. Happy Birthday, America!

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In the next issue

A variety of subjects are scheduled for the August issue of* Michigan Medicine. *They include a rundown on current medical and health legislation and its status, progress of the new MSMS negotiations service, reports on the number of office visits made to Michigan physicians during the past year and on the MSMS Task Force on Obstetrical Services' new rules for surplus OB beds. Recent legal action in Ingham County against chiropractors, a list of current special society officers, physicians' commentaries on youthful alcoholism, the Michigan Physicians Mutual, health care costs and production of more rural doctors are included. So, too, of course, are the regular features such as President Leitch's editorial, MSMS benefits to members, lists of Category I courses, news of individual physicians and component medical societies, practice management and new members. Be sure to read them all in the August issue.

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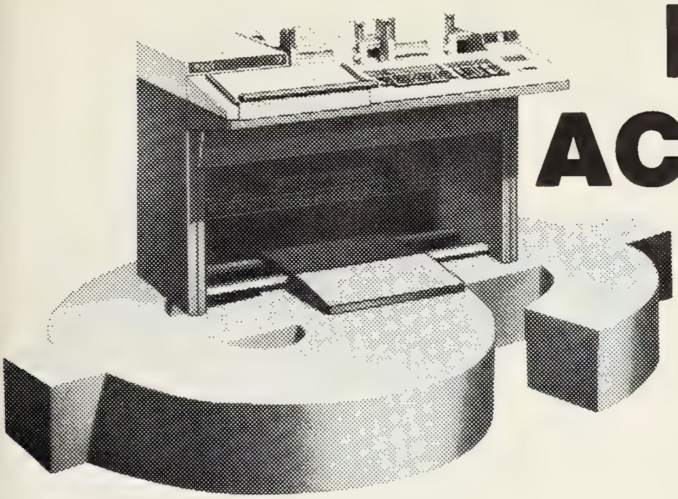

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This election year is a good time to contribute to MDPAC

Robert M. Leitch, MD
MSMS President

Politics and the activities of politicians continue to occupy a prime place in the news. These activities have both direct and indirect bearings on our everyday life.

A primary concern of physicians must be the election of the type of public officials who will reflect our interests and philosophies and the best interests of our patients and their activities. We must take time to inform ourselves of who our elected officials are and what they stand for. We must seek to elect the highest type of individual to all branches of government.

Involvement in political activitiy is a must for every physician. The simplest and least time-consuming, and yet possibly one of the most effective, methods of involvement is support of the political action committee movement.

The Michigan Doctor's Political Action Committee (MDPAC) is a by-partisan committee whose board of directors is made up of doctors and their spouses. The board takes time to find out how the various candidates feel on issues and what their attitudes are regarding medicine in order to provide support for the candidates most closely attuned to our philosophy. A $25 contribution to MDPAC is a very effective method of becoming politically involved. Even better, is a sustaining membership at $100 per year. And in this Bicentennial year, the Bicentennial Ninety-Nine Plus lapel pins should be proudly displayed by a large segment of the medical population.

Even with the convenience of a check-off on our MSMS dues billing, only about one-fourth of the doctors in the state contribute to MDPAC. Many states have much better records and Michigan surely can improve its participation. A $25 contribution to MDPAC goes a long way to help the people who direct our government relations program. They need the support of elected officials who will listen to the opposition. These people need our support in order to be elected.

If you have not already sent your contributions to MDPAC please consider doing so soon. With elections not far away this is particularly important this year.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert**
* **B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Thiamine Mononitrate	2.5 mg
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Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg
Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
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ACTION AND USES DOSAGE: 1 tablet after breakfast and supper or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets.

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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How do you benefit as an MSMS member?

– With scientific and educational services such as the Maternal Health Desk Reference Cards.

An important scientific service of the Michigan State Medical Society to its members has been the publication, over the last several years, of maternal health desk reference cards. Sponsored and prepared by the MSMS Committee on Maternal and Perinatal Health, the cards are printed each time on heavy orange card stock punched for three-ring notebooks.

The purpose of the cards is to serve as a handy reference source for family physicians, obstetricians and others seeking further information on problems and treatments of pregnancy and birth.

They are described as "a mini-textbook" for immediate access to information on obstetric and neo-natal emergencies, by Lee B. Stevenson, MD, current chairman, maternal health committee. The cards frequently contain references for further information and study, he points out.

Each card is carefully researched and written by members of the Maternal Health Committee expert in the area with which the card deals. Recent examples include "Fetal-Electronic Monitoring," in the April, 1976 issue, and "Rubella Diagnosis," which appeared in the April, 1975 issue.

The cards initially were a response to concern by the Maternal Mortality Subcommittee of the maternal health committee, which had identified areas of problems in delivering health care to mothers and infants, Doctor Stevenson continues.

Instrumental in the development of the cards were William W. Jack, MD, chairman in 1963 of the MSMS Maternal and Perinatal Health Committee; Charles Behney, MD and C. S. Stevenson, MD, successive chairmen of the Maternal Mortality Subcommittee, and C. M. Bell, MD, chairman then of the Medical Liaison Subcommittee.

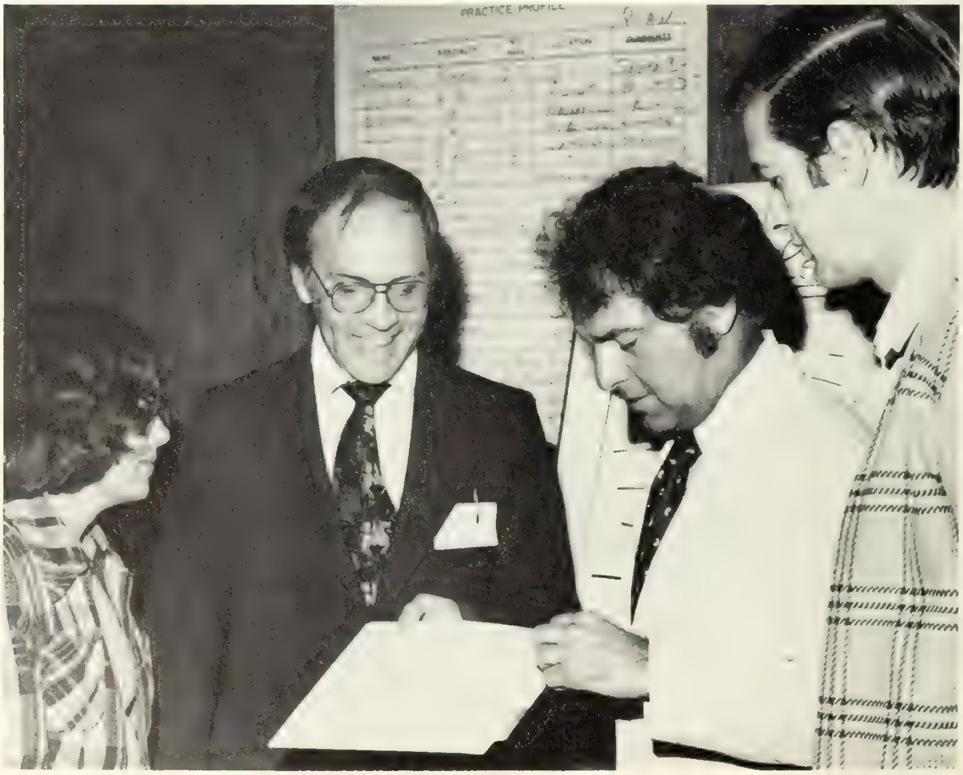
There have been 19 desk reference cards published since the Maternal Health Committee began its service in 1963. Complete sets are available by contacting MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823.

The cards are another example of how MSMS works for you.

Pertinent advice on how physicians may best manage their practices was passed along at the joint MSMS-AMA workshop June 2-3 in Southfield. The workshop, first in an annual series planned for doctors establishing their practices, drew such interest that it had to turn away registrants. The workshop was arranged by the MSMS Bureau of Economic Information.

MSMS Seminar on Practice management draws crowd

Jean Miller, MD, Detroit, left, and Darius Wampler, MD, West Pointe, NY, right, soon to locate in Holland, learned about color-coded filing systems for easy reference to patients' progress through treatment programs. Instructors were Bill Ottway and George Conomikes, left to right center, of Conomikes Associates professional management firm of Marina Del Rey, Calif.



Security, safety, flexibility keys to retirement plan

By Judith Marr
Managing Editor

It's important for the individual doctor to decide as soon as possible what retirement plan he will follow and then get started on it. That was the major message brought by Keogh Plan sponsor Eugene J. Keogh to a 1976 MSMS House of Delegates special seminar on retirement.

Former Congressman Keogh, from New York, told the doctors there is no sense in debating whether or not they should participate in a retirement plan.

"No matter how short the period you have left to contribute to retirement, the amount you accumulate is more than you would have if you did not contribute at all," he advised.

He pointed out that individuals may make contributions under the law up to the age of 70-and-a-half-years.

The silver-haired Mr. Keogh emphasized that a physician's retirement plan must be established in a way that provides a maximum of safety, security and flexibility.

"I would advise physicians to seek professional advice on their retirement plans, just as they tell patients to do," he continued. "The object is to avoid being confused as to what is the best thing to do, so that they avoid doing nothing."

Mr. Keogh, of course, believes in his own plan.

"I would advise doctors following it to set aside the maximum possible (recently raised to 15% of net income, or $7,500, whichever is the lesser). The valuable aspect of the plan is that the contributions which accumulate are tax-free." (When the physician draws on his fund in retirement years, the money is then taxable, but usually in a lower bracket.)

The original Keogh Act was passed by Congress in 1962 and made it possible for self-employed persons without pension plans established by their businesses, to set aside tax-free money toward their retirement.

It came about after an earlier revenue act in 1942 which did not allow the self-employed to set up their own pension plans. "Even though the act gave the self-employed the incentive to set up plans for their employees, little actually was done as the employers couldn't help themselves," said Mr. Keogh.

He and a highly-interested coalition of associations and individuals, including the AMA, ABA, ADA, American Farm Bureau Federation, national associations of CPAs and others, felt the injustice keenly.

"I thought it was manifestly unfair, if not unjust, for professionals, individuals, the self-employed and unincorporated business people to be denied the right to plan for their own retirement.

"My version of the problem is that there were a lot of deserving people for this legislation who were not included," said Mr. Keogh.

The 1974 legislation expanded the Keogh Plan option to employees of firms without pension plans, and upped the amount of income which may be contributed to a Keogh Plan.

Mr. Keogh predicts that in the future, contributors will be allowed to place a greater percentage of their incomes in Keogh-type plans, though he foresees no change in the maximum dollars allowed to be set-aside. He calls this "a clearing of the underbrush."

Mr. Keogh cautioned that doctors not assume that because they have the money set aside they can do anything with it. "The original idea was to create a fund for retirement. As that idea takes hold more firmly among the eligibles," he predicts, "they will be turning in the direction of a more secure, safe, and flexible type of plan."

Security, safety and flexibility are the virtues, he believes, of his Keogh Plan. For instance, he points out, the individual has the right to supplement his contributions with ordinary life insurance, if that is less than half the contribution.

"This gives the eligible individual the opportunity to lay the basis for creation of a larger estate than he otherwise might have in the event of his premature death," explains Mr. Keogh. "Yet he's contributing his funds in a medium as safe and secure as a government bond."

Mr. Keogh advises physicians to look into a flexible annuity plan, which permits the physician to contribute a varying amount to his retirement plan from year to year, according to the fluctuations in his income, without penalty or loss. The Keogh Plan also allows this type of mechanism to be used.

Mr. Keogh chose not to recommend one retirement plan over another, and he declared the potential market for such plans to be great.

But he urged physicians to adopt a plan which historically has proven a secure and safe medium for investment.

MEETINGS

See also listing of Category I programs, page 408

July 11-16 — Short Course, "Community Relations for Health Services Administration," sponsored by University of Michigan School of Public Health**

July 17 — MSMS Council, Sugar Loaf Village, Cedar, contact: Warren Tryloff, MSMS director

July 25-27 — Bi-Annual Meeting, Michigan Academy of Plastic Surgeons, Grand Hotel, Mackinac Island, contact: David B. Hawtof, MD, 15901 West Nine Mile Rd., Southfield 48075

July 25-30 — Short course, "Supervision of the Health Field: Theory, Process, Practice," sponsored by University of Michigan School of Public Health**

July 29-30 — Annual Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City, contact: Laurence P. Skendzel, MD, Munson Medical Center, Traverse City 49684

July 31-Aug. 4 — Annual Meeting and Scientific Assembly, Michigan Academy of Family Physicians, Holiday Inn, Traverse City, contact: Rita Feldkamp, Exec. Sec., 933 Wing St., Plymouth 48170

August 8-13 — Short Course, "Problems in Planning and Evaluation," sponsored by University of Michigan School of Public Health**

September 1 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director

September 2-15 — MSMS/INTRAV trip, Western European Air/Sea Cruise, contact: Marcelyn Ireland, MSMS headquarters.

September 18 — September Seminar, "Lesions of the Bone," Michigan Society of Pathologists, St. John Hospital, Detroit, contact: Robert Hendrix, M.D., Dept. of Pathology, University of Michigan, Ann Arbor 48104

October 1-3 — Michigan Regional Meeting, American College of Physicians, at Otsego Ski Club, Gaylord, contact: Beverly C. Payne, MD, F.A.C.P. 425 E. Washington St., Ann Arbor 48108

October 6-9 — Convention, American Medical Writers Association, Pontchartrain Hotel, Detroit, contact: Lillian Sablack, executive director, AMWA, 9650 Rockville Plaza, Bethesda, MD 20014

October 1-2 — Annual Meeting of Burns Clinic Medical Center at Boyne Highlands Resort, Harbor Springs, contact: Ernest W. Carpenter, MD, chairman, 560 W. Mitchell, Petoskey 49770

October 20 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director

October 29-30 — 1976 State Conference of Michigan Association for Children with Learning Disabilities at Hyatt Regency Dearborn, contact: Bea Bury, 2876 Munsfield Ct., Bloomfield Hills 48013

December 15 — MSMS Council, MSMS headquarters, contact Warren Tryloff, MSMS director

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Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the four-week period ending May 28, 1976

	1976 This 4-Week Period	1975 Same 4-Week Period	1976 Total To Above Date	1975 Total Same Date	Total Cases for 1975
Rubella	309	322	1,065	1,124	1,975
Cong. Rubella Syndrome	0	0	0	1	1
Measles	1,731	646	4,269	2,247	3,253
Whooping Cough	5	7	32	40	98
Diphtheria	0	0	0	1	1
Mumps	459	1,162	4,167	6,631	9,979
Scarlet Fever & Strep Sore Throat	1,917	1,908	12,316	12,614	23,777
Tetanus	0	0	0	0	0
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	183	243	1,008	1,204	2,877
Salmonellosis (other than S. typhi)	82	68	324	335	864
Typhoid Fever (S. typhi)	3	0	4	1	10
Shigellosis	68	60	247	328	745
Aseptic Meningitis	5	10	41	36	280
Encephalitis	4	2	33	25	168
Meningococcic Meningitis	3	7	35	49	76
H. Influenza Meningitis	7	7	53	50	142
Tuberculosis	91	117	534	466	1,220
Syphilis	89	122	477	681	1,614
Gonorrhea	2,467	2,352	12,867	12,180	32,472

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

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commentary

How the U.S. can duplicate Canada's malpractice status

By Leland E. Holly II, MD, Muskegon

The professional liability problem is extremely complex. It arises from an environment of many influencing and causal factors. It defies a simplistic solution.

The Canadian situation (similar to most European environments) is cited as an example of what we need in the USA. Let us clearly understand some of the factors operating in the Canadian environment.

1. There are fewer Canadians and they are living in a far less urban world.
2. Canadian medicine is nationalized and heavily controlled.
3. Canadians historically have been far less dollar-conscious and litigious than their US counterparts (although this is now changing quite rapidly).

Doctor Holly

4. All doctors must belong to the Canadian Defense Association.
5. Every complaint is hotly contested by the Association and even rare settlements are strongly negotiated by that knowledgeable and tough organization.
6. "Pain and suffering" awards are almost non-existent (especially by comparison).
7. The Association can and does sue (often successfully) for cost recovery in suits they win.

8 .Discovery proceedings are extremely expensive and must be completed before institution of a suit. (All records are available in a controlled and expensive manner.) Suits are not "fishing expeditions."

9. The defendant has the right to refuse a jury trial.
10. There is no contingency fee. (This, too, is changing in Canada.)

Which of these elements is most important to the Canadian professional liability experience?

I submit that the Canadian experience is a reflection of the total environmental situation, in part made up of these 10 factors. If we are to approximate their experience, then we must do our best to approximate their environment.

To achieve such an approximation in the USA where the social and legal system has evolved in a far different way, a compromise must be comtemplated. In that compromise, as in all effective and lasting compromises, every party must perceive its fairness and be able to live comfortably within its restrictions.

We need all the help we can get from attorneys, the public and government to generate our Michigan brand of a Canadian approximation. We yet need (among other environmental adjustments):

1. A clear definition of malpractice.
2. A ceiling on (if not abolition of) "pain and suffering" awards.
3. Annuity type payments.
4. Improved Statute of Limitations, and an
5. Affidavit of merit.

We cannot be vindictive. We cannot disregard the rights of others. We need everyone's help to achieve a justice perceived by all to be just that.

Debating nuclear energy?

Michigan physicians debating the controversial issue of nuclear power development might find some guidance for their thoughts in the recent official stand taken by MSMS on the subject.

At the 1976 MSMS House of Delegates Annual Session in Troy, the delegates adopted the following position statement:

"That MSMS, always keeping in mind that the prime responsibility of the medical profession must be the health of the people, go on record as advocating a public policy of cautious and reasoned development of nuclear power in Michigan because of safety and radioactive waste disposal problems which have the potential for harmful effects on the public health and the environment."

The position statement was adopted in lieu of a resolution passed by the delegates in 1975. That resolution directed the MSMS Council to study the Northern Michigan Medical Society's suggestion for a five-year moratorium on nuclear power plant construction coupled with intense research and development programs for other sources of electrical energy and for conservation of energy.

Michigan physicians may use their own discretion in deciding whether to participate in the referendum campaign to allow voters next November to decide whether to limit attorney's contingency fees in medical malpractice cases.

This was the decision of the MSMS House of Delegates at its recent annual meeting in Troy.

To assist the Michigan physician in deciding whether he wishes to participate, **Michigan Medicine** *presents the following summary of the views of those proposing the referendum.*

Why Kent County doctors want to limit contingency fee

By Alfred B. Swanson, MD, Grand Rapids Medical Malpractice Action Committee

The Kent County Medical Society, which met in Grand Rapids, June 15, 1976, unanimously passed a resolution calling for the limitation of the "bonanza" contingent fee which acts as an incitement to litigation in medical malpractice cases. Since that time, a special Malpractice Action Committee has been appointed by the president of the society. After thorough research, our legal counsel recommended using the citizen's initiative method for placing a referendum on the ballot to obtain a constitutional amendment to allow the people of Michigan to act on the crisis occurring in their medical delivery system.

The substance of the amendment is to limit contingent fees in medical malpractice cases to the lesser of either the amount agreed upon between the attorney and client, or the following schedule:

> 50% of any amount recovered up to $10,000, 10% of the next $90,000 recovered and 1% of any amount over $100,000 recovered.

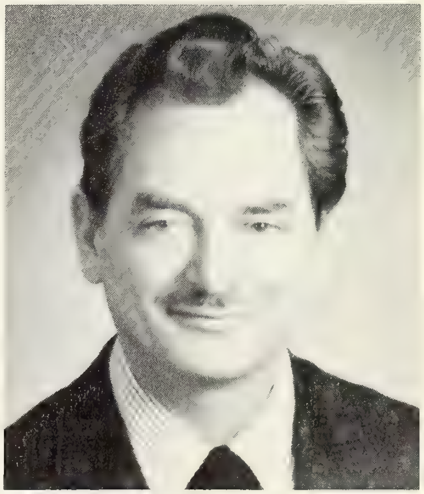
The expenses of litigation are borne by the client and are not included in this schedule. This also does not preclude the lawyer and client from using a fee-for-service contract instead of the contingent fee if desired.

The committee has stated that the efforts of the Legislature and the Governor in passing 14 bills to help control the medical malpractice crisis were greatly appreciated. They, however, have fallen short in truly controlling the realistic problem which is the tremendous and prohibitive escalating costs of medical malpractice insurance premiums.

Fee problem is spearhead

The committee is fully aware of the complexity of the malpractice crisis and is using the "bonanza contingent fee" problem as the spearhead of a many-pronged solution which they are recommending to the people of Michigan, to the Governor, to the state legislature and to other medical societies. These considerations include:

1. The referendum to rebalance the contingent fee system.
2. A call for a proper legal definition of malpractice which will separate the "unhappy result," which is not the fault of the doctor or hospital, from incompetence and negligence. (Medical malpractice can be defined as when: a patient suffers harm in a treatment situation through outright incompetence or gross negligence or if, after a mistake is made, no proper remedial action is taken in an appropriate time.)
3. A reasonable and appropriate definition for the "informed consent" for treatment which presumes the assumption of risk and is both ethical and realistic and which can stand up under retrospective legal scrutiny. (Was the subject fully aware that risks were being assumed and was any requested information denied?)
4. The further development of a fair statute of limitations (two years after cause).
5. Further promotion and implementation of the Arbitration Panel concept which can lower the costs of the complicated tort system. (Arbitration, however, does not decrease the incentive for promoting suits.)
6. A re-evaluation of the present insurance concept which requires the physician and the hospital to be the sole guarantors of every patient's health. We should have consideration for a new insurance program that will compensate patients for accidents derived in the medical health system. It should spread the natural risks of health care over the millions of patients rather than a few thousand doctors and hospitals.
7. Appropriate penalties for those who would pursue frivolous suits (in Canada the loser pays the court costs of the winner). This has grown to be an excellent method of restricting the plaintiff and his attorney from pursuing nonmeritorious cases.



Doctor Swanson

COMMENTARY/*Continued*

It could also be used by plaintiffs who have meritorious suits.

8. A monitoring of the medical and legal professions to control the incompetent, the negligent and the devious who would abuse the public trust.
9. The development of hospital grievance committees to be on the alert for any substandard treatment conditions at the local level.
10. Required educational programs for health professionals stressing not only new developments in science, but also the continuing importance of medical ethics and dedication to the public interest.

Not eliminating the fee

In focusing on the contingent fee as the spearhead of this effort, the committee is not taking the position that the contingent fee should be eliminated (though the House of Delegates of the Michigan State Medical Society has so voted). Our proposal is to frontload the contingent fee with a higher percentage for the lawyer in smaller award cases. This would create an incentive for them to take the smaller cases which are in greater preponderance and which are now not receiving the proper legal attention. In changing the legal fee for the over-$100,000 award, the committee reasons that *if the patient deserves a larger award, that money should go to him and not his attorney* as a bonus for his "enthusiastic pursuit of the case."

Our research into the findings of the Michigan Court Docket Survey of July of 1975, and that of the Secretary of Health, Education and Welfare's Commission on Medical Malpractice of 1973, shows that a $14,000 fee after expenses in a $100,000 suit is appropriate for the time involved. The survey stated that the average fee per case reported by defense counsel in malpractice cases in the period 1970-72 was $4,900. The H.E.W. report further states that in suits over $100,000, the benefit to the plaintiff by having the attorney participate in the award is negligible. This is especially true where there is a large settlement without litigation which necessitates only a relatively small expenditure of time by the patient's lawyer.

In the days when suits were controlled by conscientious lawyers and judgements were small, the contingent fee made greater sense and was a reasonable reward for effort expended. The Court Docket Survey has shown, however, that as judgements accelerated in size, and as the size and number of "bonanza fees" increased, the incentives to break the rules and the amount of money with which to do it likewise increased.

It has been shown that the patient receives as low as 16¢ of the medical malpractice premium dollar. More than 50% of that dollar goes for legal fees and the rest as overhead for the insurance companies. These enormous legal fees support the contention of Professor Jeffrey O'Connell, father of the no-fault insurance, and others, that the present fault system is simply too expensive for society to bear. The Physicians' Crisis Committee Court Docket Survey describes a costly legal system which is out of control of the public interest it no longer serves. The principal beneficiaries of this medical malpractice system are not the victims of medical malpractice, but are actually the small percentage of lawyers who file and defend these cases. In just three counties in Michigan in 1970-74, the 1,910 cases filed and defended by a group of law firms will produce estimated gross legal fees of from $64 million to $74 million, two thirds of which will probably go to less than 10% of the firms involved. It further showed that 90% of cases were settled out of court for an average of $74,000 and that more than $42,000 of this award went for legal fees. Statistics have also shown that eight of ten cases filed are not the result of incompetence or negligence or true malpractice on the part of the hospital or doctor.

Sitting ducks to avarice

Why has the malpractice crisis descended on our society like a devastating storm? Medical care is actually better now than at any time in our history. The medical profession has in the last 50 years increased life expectancy by one-half, has eradicated plagues and epidemics and has controlled infectious diseases. It has redefined the role of the hospital from a place to die into a place to live. It has improved the chances of surviving illnesses which were before hopeless, and has given new hope to victims of heart disease, stroke and cancer. It has developed remarkable diagnostic and monitoring devices. It has courageously adopted the advances of the technical revolution to provide transplanted organs and synthetic joint replacements to give a renewed quality of life and hope to those who are crippled.

How can this tremendous effort now be found not good enough? Why must a doctor all of a sudden be the guarantor of every person's health that he sees: It isn't a question of suddenly discovering a bunch of bad doctors treating good people badly in bad hospitals. It is, rather, because bad laws are being interpreted and promoted by a small group of bad lawyers. It is also because of a new consumerism attitude by some people that think that every adversity in life is someone else's fault and must be paid for. Unfortunately, doctors are constantly exposed to these people and their adversities and become sitting ducks to their avarice.

The insurance industry, with few exceptions, has failed miserably to represent both physicians and the public. Their immediate and sole response was to multiply premiums to exhorbitant rates. Instead of proposing solutions when the going got hot, the industry turned and ran. Of little concern to them was the fact that doctors would be left totally unprotected and that society would be left without physicians to care for them. Again, "society was the victim of the system." The state Legislature has enacted a law to provide some insurance for doctors in the state and the Michigan State Medical Society has developed an insurance company. The rates for this insurance which doctors must pay are continuing to skyrocket within these plans and, unfortunately, it is only symptomatic treatment and does not get to the root of the evil. Many doctors are planning to go without insurance. However, hospital boards, from a self-protective point of view, are afraid to let them practice in their institutions.

Legal system in crisis

Too few lawyers will recognize and admit that the story of the malpractice crisis is really the story of an entire legal system in crisis. However, society is beginning to recognize this and unless the law profession takes steps to correct it in the public interest, society will surely do it for them.

It has been suggested that the medical profession wait patiently for correction of the present crisis. We have waited since 1969 when the Secretary of the HEW commission on medical malpractice was initiated. The then-Secretary, Robert Finch, stated to the American Academy of Orthopaedic Surgery national meeting that the contingency fee arrangement was the main cause of the malpractice crisis and that he thought something should be done about it. Since then, malpractice premiums have gone up 2000%.

The legal profession in the 1975 contingency fee adjustment by the Michigan Supreme Court was asked to accept less than the standard 50% of the client's award. They were told to restrict their fee to one-third of the first $250,000 and one-fourth of the next $250,000. Most doctors in the state of Michigan cannot get insurance for more than $100,000 which simply means that any suit over $100,000 would take the doctor's savings and destroy his legacy for his wife and children.

The Michigan State Bar representative described a "small suit" as under $250,000 and an $83,000 fee as fair. We feel that this is an extremely high award and an atrocious fee. He also recommended that doctors of Michigan be "disbarred" for malpractice suits. We all agree the incompetent of all professions should be restricted, but does he realize that one doctor in three in the State of Michigan has had a so-called malpractice suit filed against him. In the higher risk specialties, the average ratio is one suit per doctor. Does he think all the doctors in the state should be eliminated? We also wonder if he thinks doctors should also work on the contingent fee system to provide enthusiastic care to difficult cases? Perhaps one-third of a patient's life earnings if we save his life or put him on his feet?

These so-called malpractice suits are not restricted to bad doctors; they are the albatross of the finest physicians of our community. They are destroying the finest medical delivery system in the world and the public should know it. The unbearable burden of the malpractice ogre is the manufacture of certain members of the law profession and the people who feel it is now socially acceptable to kill a doctor or a hospital and to accept a huge money award for alleged failure to relieve them from pain or disability.

We are confident that the majority of attorneys in the noble and honored law profession who work on a proper fee for service basis do not really support those in their profession who would bargain for a portion of the clients award to ensure enthusiastic legal representation. The public wants the best possible medicine for the best possible price and they also want the best legal aid for the best possible price. Perhaps, it is not without reason that the law profession should also offer their "Blue Cross" and legal-aid and legal-care as have the providers of medical services.

Fight is to save medicine

The people of Michigan have one of the best health delivery systems in the world. It will soon be immobilized because doctors and hospitals cannot afford to pay the outrageously high medical malpractice premiums. In other parts of the country doctors have gone on strike, retired or moved. In this state we are fighting to preserve our medical delivery system because we believe in it. The present problem of skyrocketing insurance fees unchecked, by 1977, will result in a "California situation" for the doctors and hospitals of Michigan.

The best protection for a patient is the ethical, dedicated and well-trained health professional who is concerned and sympathetic to his welfare and who wants to give the best possible medical care at the best possible price. The medical malpractice crisis is destroying that protection. The hospitals and doctors are not going to hang and slowly twist in the wind while the malpractice crisis develops into a disaster. We are taking this issue to the people. The citizen's initiative is democracy in action. Changing the constitution is basic to our government. The method provides the solution of problems by taking them directly to the people.

The "poor man's legal fee" has become his and society's burden, medicine's ox is being gored, the public interest is being abused and the people are being ripped off. And they know it. They will have their chance to put balance back into the situation at the November, 1976, election if the 300,000 needed signatures on the petitions are obtained.

You will be interested to know that the overwhelming majority of the people, when asked, are signing the petitions which are now available in doctors' offices. It is simply a question of the logistics of presenting the problem to the people. They appear willing to make the decision.

More, or better, care may be the choice

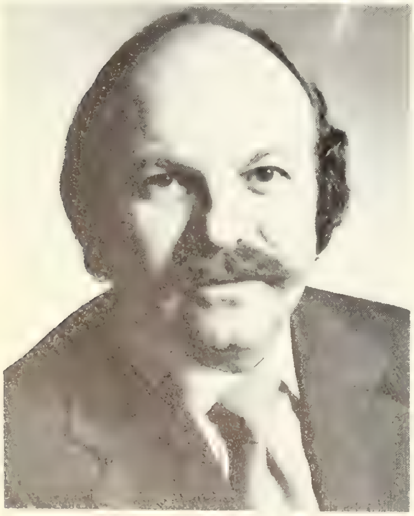
By Reuven Bar-Levav, MD
Detroit

The revolution of expectations that has occurred, especially since World War II, has encouraged people to expect more for less, and to be very impatient at not being given immediately what they wish.

As a result of fantastic promises made by dreamers and politicians, medical care is no longer considered a privilege but, instead, is increasingly being looked upon as a basic right.

Greater availability of third party payments has dramatically increased the demand for medical attention both in public facilities and in private practices. Patients often do not have to pay directly for services rendered, although they do so indirectly through taxations and the payment of insurance premiums. As a result, medical care is considered by many to be "free," and patients come with relatively minor symptoms, and then they come back and back again.

Our age is an inconoclastic one in which large segments of the population delight at the sight of fallen heroes. The medical profession as one of the most respected institutions of our society is being criticized and harassed by parts of the public, the media and government. We are envied, criticized and humiliated, even as the services of physicians are sought ever more eagerly.



Doctor Bar-Levav

In this charged atmosphere it seems impossible to take more time with patients. A basic dilemma is thus faced by every practicing physician, whether in private or institutional practice: Is he or she going to treat each patient as an individual, deserving of dignified and *proper* medical attention, or is a patient to be treated as a statistic, not as a whole human, but as part of a "patient population?" Are physicians going to treat every patient properly according to his or her needs, or will the mode of practice be determined by administrators, setting minimum patient quotas and maximum hospital stays, or by the clamor of patients for an apppointment?

More time cannot be taken unless it is made free first. This is realistic and *can* be achieved if a basic change in the philosophy of practicing medicine is instituted. Physicians must decide the absolute minimum time that must be spent with each patient to provide him or her with *proper* medical care. Every patient seen would be allocated such time, regardless of the number of people seeking help. Only true emergency care would be available without delay. Many patients would have to wait months for a regular appointment.

Physicians' incomes need not change for the worse. The unit of charge for medical services has always been time. It still is. The highly skilled time of physicians, coupled with their willingness to assume the heavy responsibility for the very lives of others is what they are compensated for. The concern and interest shown by physicians has no price attached to it.

Some physicians will charge more and some will charge less per unit of time, depending on their skill, experience, prestige, reputation and specialty.

Still and all, only a limited number of hours is realistically available, and only a limited number of patients can realistically be taken care of properly. We must limit our practices not only to *types* of patients we see, but also to *numbers* of patients we can treat without mistreating.

Patients come again and again with minor symptoms and with more serious problems, not only for specific treatment but also in search of something else. What they seek is a meaningful contact with another person to reassure them that in spite of great fears their continued existence is not in danger.

Assembly-line medical care promises more than it can deliver. The patient is not seen at all, only his pathology. He leaves hungrier and angrier than he was before.

It is possible that if physicians took a little extra time with each patient, the total need for visits to doctors might be reduced enough to compensate for it.

By seeing a smaller number of patients per day and by taking a little extra time with each, the total number of calls upon doctors everywhere might well be decreased.

Each physician must eventually choose. Is he to practice in a sane way that allows not only for the making of a reasonable living, but also for living reasonably, or is he, too, going to be swept into the whirlpool of insanity that is threatening to engulf all?

As patients are rushed through, hurried and impersonal care is given to all. With increased pressure, the quality of care proportionately decreases. More and better medical care may not be possible. It may have to be more *or* better.

Physicians must state clearly that their response to the ocean of demands will be dictated by rationality and reason, not by guilt or by greed. *We* have not made the promises, and *we* cannot keep them. The complaints will have to be redirected at those who deluded the public into thinking that more *and* better medical care could be provided by political fiat.

12-hour claims are nothing new.
12-hour relief is.

NEW

Novafed® A Capsules

Each capsule contains pseudoephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg.

Controlled-Release Decongestant Plus Antihistamin

It goes the distance.

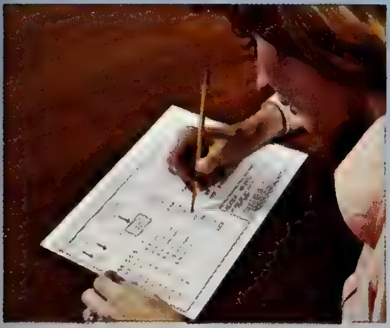
Clinical studies confirm full 12-hour effectiveness.

For years, patients have heard of drugs providing long-lasting relief. But after six or eight hours, they often run out of relief. And it's too soon to take the next dose.

Now, with Novafed A, Dow introduces a prescription capsule with 12-hour effectiveness in relieving allergy and hay fever symptoms. Placebo-controlled clinical studies show that the high level of decongestant in Novafed A provides relief for as long as 12 hours. At the same time, its antihistamine relieves the patient's itchy eyes and runny nose *without* the excessive dryness of anticholinergic agents.

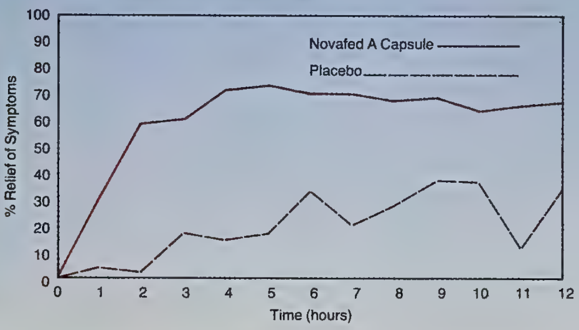
Prompt onset of effect is followed by full 12-hour relief.

(Please refer to the following page for bioavailability studies and prescribing information.)



Patients with severe pollen allergies were tested during hay fever season in a countryside environment and asked to rate severity of five different symptoms on a scale of 1 to 4.

Clinical Study: Degree of Relief from Itchy Eyes and Nose and Throat, Watery Eyes, Runny Nose*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DOW®

Specialists in Cough and Cold Care

NEW

Novafed A Capsules

Each capsule contains pseudoephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 m

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.

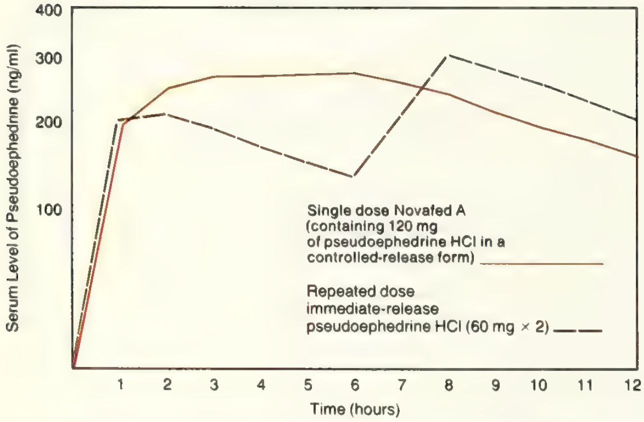
Prompt onset and sustained serum levels over 12 hours

A bioavailability study confirmed that the sustained 12-hour action of Novafed A was comparable to that of immediate-release medication taken at 6-hour intervals.

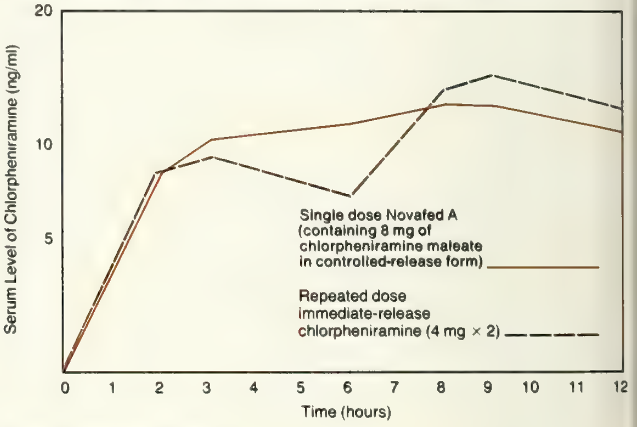
The chart at the left shows the serum levels of pseudoephedrine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 60 mg. pseudoephedrine hydrochloride in an immediate-release form. Serum levels of pseudoephedrine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

The chart at the right shows the serum levels of chlorpheniramine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 4 mg. chlorpheniramine maleate in an immediate-release form. Serum levels of chlorpheniramine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

Comparison of Mean Serum Levels of Pseudoephedrine Following Novafed A and an Immediate-Release Reference Formulation*



Comparison of Mean Serum Levels of Chlorpheniramine Following Novafed A and an Immediate-Release Reference Formulation*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DESCRIPTION: Each NOVAFED A capsule contains 120 mg. of pseudoephedrine hydrochloride and 8 mg. of chlorpheniramine maleate. The specially formulated pellets in each capsule are designed to provide continuous therapeutic effect for about 12 hours. Nearly one-half of the active ingredients is released soon after administration and the remainder is released slowly over the remaining time period.

ACTIONS: NOVAFED A combines the action of a nasal decongestant, pseudoephedrine hydrochloride, and an antihistamine, chlorpheniramine maleate. These ingredients are combined to provide prompt and sustained nasal and upper respiratory decongestant and antihistaminic action.

INDICATIONS: NOVAFED A is indicated for the relief of nasal congestion and eustachian tube congestion associated with the common cold, sinusitis and acute upper respiratory infections. It is also indicated for perennial and seasonal allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods and for mild, uncomplicated allergic skin manifestations of urticaria and angioedema. Decongestants in combination with antihistamines have been used for many years to relieve eustachian tube congestion associated with acute eustachian salpingitis, aerotitis media, acute otitis media and serous otitis media. NOVAFED A may be given concurrently, when indicated, with analgesics and antibiotics.

CONTRAINDICATIONS: Symphathomimetic amines are contraindicated in patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy. Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack, and in patients receiving MAO inhibitors.

Children under 12: NOVAFED A controlled-release capsules should not be used in children less than [illegible] years of age.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

Hypersensitivity: This drug is contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or antihistamines. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

WARNINGS: Sympathomimetic amines should be used judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy. Sympathomimetics may produce central nervous system stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children. Chlorpheniramine maleate has an atropine-like action and should be used with caution in patients with increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension or in patients with a history of bronchial asthma.

Do not exceed recommended dosage.

Use in Pregnancy: The safety of pseudoephedrine for use during pregnancy has not been established.

Use in Elderly: The elderly (60 years and older) are more likely to have adverse reaction to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Therefore, safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

PRECAUTIONS: This drug should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation.

Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache and nervousness, blurring of vision, heartburn, dysuria and very rarely, dermatitis.

DRUG INTERACTIONS: MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other central nervous system depressants may have an additive effect.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours. Do not give to children under 12 years of age.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: NOVAFED A is supplied in red and orange colored hard gelatin capsules, monogrammed with the Dow diamond followed by the number 109, in bottles of 100.

Dow

DOW PHARMACEUTICALS
The Dow Chemical Company
Indianapolis, IN 46268

Specialists in cough and cold care

Anatomy of the directory of Ingham County MDs

John B. Kantner, Executive Director
Ingham County Medical Society

Physician directories published by Nader-styled consumer groups are much like a small tempest in a very large teapot and about as significant.

Lansing area physicians were the first in Michigan to be a directory target. They came out of the experience looking good.

Similar directories have been produced in other areas of the United States such as Prince Georges County, Maryland; Springfield, Illinois; Ithaca and Syracuse, New York; and Minneapolis. According to the *American Medical News,* the guides have had little, it any, effect on the private practice of medicine where they have appeared.

The 1976 Lansing Area Doctors Directory came out in April of this year. It is nicely put together. You can buy it for 95 cents at newsstands and discount stores. Whether it solves your problem about finding a doctor is open to question.

The Directory was published by the Public Interest Research Group in Michigan (PIRGIM). PIRGIM is an organization of some 40,000 college students in Michigan. It calls itself Michigan's largest and most active advocate for the consumer. PIRGIM describes its function as an "independent, non-profit public-interest advocacy organization which investigates problems, then uses public education, administrative procedures, legislative lobby, and litigation to work for needed change."

Background of the directory

The idea for the directory originated with a Michigan State University student early in 1975. She was having difficulty finding a pediatrician for her children. She felt that if there were a directory of primary care physicians listing the types of services they provide, that would solve the problem of finding and selecting a physician.

The MSU student took the idea to PIRGIM, and the directory project got underway. The Ingham County Medical Society first learned of PIRGIM's plans for a directory when its members in primary care received an extensive questionnaire.

Since some of the physicians were confused about what to do about the questionnaire, the society recommended that they defer completing the questionnaire until the matter had been studied by an appropriate committee. With little or no response from the physicians, the PIRGIM project practically came to a halt.

Subsequently, PIRGIM officials were invited to meet with the society executive committee to present their case, which they did at great length. The president of the society appointed an ad hoc advisory committee to work with PIRGIM. The advisory committee met with PIRGIM and assisted them with the questionnaire as well as setting up some ground rules. For instance, a physician who responded to a questionnaire would have the opportunity to see what information would appear in the directory about him prior to publication.

PIRGIM then sent out a second questionnaire with a cover letter from the advisory committee indicating that it was not unethical to complete the questionnaire and that members might do so if they wished on an individual basis.

What's inside the Ingham directory

The questionnaire went to physicians in the specialties of family practice, internal medicine, Ob-Gyn, pediatrics, dermatology, general surgery, ophthalmology, ENT, psychiatry and urology.

The questionnaires sought information on the doctor's training, board certification and hospital affiliations. It asked about office procedures such as hours, after-hours coverage, house calls, accepting new patients and time required to get an appointment. Another part of the questionnaire asked about fees and billings. Much of the questionnaire was devoted to the doctor's services including whether he prescribed drugs by generic name, let patients read their medical records, encourage breast feeding and so on.

PIRGIM was obviously delighted with the society cooperation in their project. With some help and money from the College of Urban Development at Michigan State University, the directory was finally published.

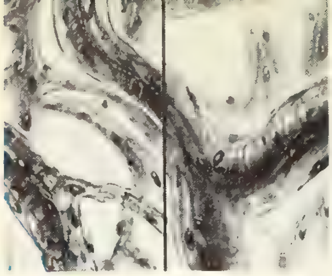
It has some very good general information in its introduction. It describes the training procedures for a physician, what the different doctors do by defining specialties and offers some suggestions on the way to select a doctor. In addition it includes a glossary of medical terms found in the directory as well as an explanation of coding on a prescription.

The effects of the directory

Now that the Lansing directory is out, has it accomplished its purpose helping people find and select doctors? Probably not. For one thing, the directory is far from a complete listing of primary physicians and their services. For example, only 12 family physicians out of an approximate potential of 50 general practitioners in Ingham County responded to the questionnaire.

There has been no decrease in the number of telephone requests for referrals to physicians received daily by the Ingham County Medical Society Executive Office. The society continues to receive up to 50 or more requests each day from people looking for doctors. For a time right after the directory appeared in stores, there was a slight increase in the number of referral requests. However, we have no data to verify whether this was caused by the frustration of directory buyers who could not get into practices of the doctors listed.

When women outlive their ovaries...



The menopausal "flush" is believed to result from an autonomic nervous system imbalance due to estrogen deficiency. Here, illustration shows artist's interpretation of "normal" vs. dilated arteriole-capillary-venule network.

"It seemed like I was having one flush after another. It wasn't just a nuisance... it was a real problem."

The menopausal flush is the classic sign of estrogen deficiency...generally recognized as a clear indication for treatment.

"The flushes were
bad enough...
but the sweats
at night were
almost too much."

This wasn't always the case.

There was a time when the symptoms of the menopause went untreated...when women were expected to suffer the severe flushes and sweats of estrogen deficiency in silence or, at best, with a minimum of encouragement and understanding.

Now, with effective estrogen replacement therapy, women do not have to endure these distressing symptoms. In the great majority of cases, PREMARIN (Conjugated Estrogens Tablets, U.S.P.) can promptly control such vasomotor symptomatology...provide classic relief for classic symptoms during a troublesome period of physiologic adjustment.

Three studies have reported an increased risk of endometrial carcinoma in association with the postmenopausal administration of exogenous estrogens. For further information see "Warnings" in prescribing information.

For the classic symptoms of the menopause

PREMARIN®
(CONJUGATED ESTROGENS TABLETS, U.S.P.)

CONTAINS
NATURAL
ESTROGENS
EXCLUSIVELY

See next page for revised prescribing information.

BRIEF SUMMARY

(For full prescribing information, see package circular.)

PREMARIN® Brand of
CONJUGATED ESTROGENS TABLETS, U.S.P.

Actions: Estrogens are responsible for development and maintenance of the female reproductive system and secondary sex characteristics. They cause the growth and development of the vagina, uterus, and fallopian tubes, and enlargement of the breasts. Indirectly, they contribute to the shaping of the skeleton, maintenance of tone and elasticity of urogenital structures, changes in the epiphyses of the long bones that allow for pubertal growth spurt and termination, growth of axillary and pubic hair, and pigmentation of the nipples and genitals. Estrogens are also involved in psychologic and emotional aspects of feminine behavior. As estrogen levels increase during the menstrual cycle, there is a sense of vigor and well-being, and in the menopausal period estrogens aid in relieving nervous symptoms (*e.g.* anxiety, depression and irritability) due to estrogen deficiency. Decline of estrogenic activity at the end of the menstrual cycle can bring on menstruation, although the cessation of progesterone secretion is the most important factor in the mature ovulatory cycle. However, in the pre- or non-ovulatory cycle, estrogen is the primary determinant in the onset of menstruation. Estrogens do not induce ovulation.

Estrogens affect calcium and phosphorus metabolism, and are involved in maintenance of normal bone structure. In prolonged estrogen deficiency states, administration of estrogen acts to prevent associated bone degenerative changes.

Estrogens appear to be responsible for the relatively greater amount of alpha-lipoprotein and correspondingly lower amount of beta-lipoprotein found in premenopausal women as compared with men.

Estrogens affect the release of pituitary gonadotropins and may also deplete the gonadotropic content of the pituitary.

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications for use as follows: **Effective:** As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus. **"Probably" effective:** For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.

Warnings: Three separate studies have reported an increased risk of endometrial carcinoma in association with the postmenopausal administration of exogenous estrogens. Smith *et al.*[1] retrospectively compared the records of 317 patients with endometrial carcinoma with the records of an equal number of contrast patients having cervical, ovarian, or vulvar neoplasms. The unadjusted relative risk estimate of endometrial cancer was 4.5 times greater in women exposed to estrogen therapy. The type of estrogen used, the preparation, and the dosage were not considered in this study. These factors may play a role in modifying the average relative risk found in this study. The authors also suggested that there may be a relationship between increasing risk and the duration of administration; however, the data are not conclusive on this point. A second retrospective study reported by Ziel and Finkle[2] examined the records of 94 patients with endometrial carcinoma and those of a two-fold contrast series from the same health plan population. The estimate of relative risk was found to be 7.6. In addition, the authors reported a relative risk estimate of 5.6 for a duration of exposure of 1 to 4.9 years, and 13.9 for exposure of 7 or more years. In this study, conjugated estrogens were reported to be the type of estrogen used. Mack *et al.*[3] retrospectively studied 63 cases of endometrial carcinoma and a four-fold contrast group. The relative risk of endometrial carcinoma was estimated to be 8.0 for any estrogen usage, and 5.6 for conjugated estrogen usage. The relationship between relative risk and duration of use could not be conclusively described from the data in the study.

Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations. Such physical examinations should be repeated at regular intervals, at least annually, during estrogen therapy.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Estrogen usage may cause preexisting fibromyomata to increase in size; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
increased incidence of gallbladder disease
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

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Menopausal Syndrome—1.25 mg daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg to 1.25 mg daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg to 1.25 mg or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

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No. 867—Each *red* tablet contains 0.625 mg, in bottles of 100 and 1,000. Also in unit dose package of 100.
No. 868—Each *green* tablet contains 0.3 mg, in bottles of 100 and 1,000.

References: 1. Smith, D.C., Prentice, R., Thompson, D.J., and Herrmann, W.L.: Association of exogenous estrogen and endometrial carcinoma, N. Engl. J. Med. *293*:1164-1167, 1975. 2. Ziel, H.K., and Finkle, W.D.: Increased risk of endometrial carcinoma among users of conjugated estrogens, N. Engl. J. Med. *293*:1167-1170, 1975. 3. Mack, T.M., Pike, M.C., Henderson, B.E., Pfeffer, R.I., Gerkins, V.R., Arthur, M., and Brown, S.: Estrogens and endometrial cancer in a retirement community, submitted for publication.

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This Michigan Medicine, *published on the 200th anniversary of our country's founding, is dedicated to that principle.*

It is not a look back at what has happened, but a focus on the future and what can and should be done. It is an effort to urge doctors to become involved in the politics of their freedom, in the workings of their government.

Its articles together are a plea for MDs to join that noble experiment. Read along and find out how, doctor. Become an active member of the world's greatest political system.

Our Nation's Capitol

Doctors, let us become better political activists

By Brock E. Brush, MD
MSMS Past President

The Bicentennial year for the USA is a great philosophical milestone. It is popular to look backward and forward at the state of one's vocation or art; in our case, the healing art.

We can look back with great pride on the accomplishments of the noblest of the professions — the eradication of a great many diseases such as tuberculosis, smallpox, polio and so on. America has had the finest health care delivery system in the world and our people have been the healthiest. Excellent health care has been available to all those who could afford it and to those who could not.

May we look into the future?

Our American doctors over the years have given generously of their time — amounting to millions of hours — to the needy. The medical profession has won the respect and devotion of the people — the most respected of the professions.

Now, may we look in the other direction — into the future. It seems incredible that the profession of medicine is today fighting for liberty and freedom — this time not from England, but from our own government.

It is difficult to be enthusiastic about the future.

Our profession has done such a tremendous job with little government interference. But now, we face expanding government regulations, expanding "like some monstrous protoplasmic blob that threatens to snuff out economic freedom and initiative."

We now fear unbelievable governmental regulations telling the doctors where to practice and how to practice. And all these years the doctors have performed so well — with little interference.

"Now here's Norman Hill with a commentary on Alan Sayer's analysis of Harrison Gilby's interpretation of Ford Burton's look at the political scene."

Doctor Brush

The costs of medical care under new government programs will be astronomical when thousands upon thousands of lay persons are given jobs in the health care field.

The experiences of Britain, Sweden and so many other countries have shown beyond a doubt that health costs go up and care goes down whenever big government takes over. Government operation has proven inefficient in every area. It can never be compared with private enterprise.

What is my charge to you?

Well, just roll up your sleeves to become a better political activist. Be willing to participate — to show up and testify — to protect the heritage of our great profession and guide it onward to ever improve its services to the American public.

Our profession, as never before, needs a united voice if we are to continue our battle for freedom and liberty for our doctors, just as our forefathers fought 200 years ago for a better world. They placed their jobs, possessions and their lives on the line. Remember, four doctors signed the Declaration of Independence.

What kind of stuff are we made of? How many of us today will sign a new Declaration of Independence — and stand up to volunteer our services?

I am sure that MSMS will meet and master the challenges of today so that in the year 2076 others will say that our generation of physicians served their profession and the public well.

County societies make their own political clout

By Judith Marr, Managing Editor

One of the best ways for Michigan physicians to become involved in the legislative process is through their county medical societies. County societies offer the advantages of organization and close, local touch relationships.

Several MSMS component societies now hold regular meetings with their legislators and congressmen, and their members recommend the approach to other component society members.

"If every county society did this, so we had some contact with every legislator, we would have the ballgame won," comments Richard Rapport, MD, chairman of the Genesee County Medical Society's legislative action committee.

"We've had a positive impact on the legislators who come to our meetings. One who felt quite hostile in the beginning now feels much better about doctors," says Douglas Wacker, MD, Ingham County Medical Society legislative chairman.

In Genesee, the physicians hold a breakfast meeting the first Monday of each month the legislature is in session. All area representatives and senators are invited, as well as union representatives, city and county government officials, area health agencies and Congressman Riegel's representatives.

While there is no rigid format, the meetings generally include a designated topic or issue with an "open agenda" feature which allows for introduction of individual concerns.

"There is an excellent exchange of concerns and interests between the physicians and the elected representatives in the various levels of government at the GCMS meetings," says Norman Anderson, GCMS executive director.

The Genesee program has been in existence over five years, with Doctor Rapport in charge from the beginning.

"It's working. It's a very free and open discussion," says Doctor Rapport. "It's designed to educate us as well. I've learned a lot about the legislative process."

To be successful, Doctor Rapport observes, the meetings with the legislators must be on a regular basis. The physicians must get to know their legislators, and the topics of discussion must be good.

With those measurements in mind, the Kent County Medical Society's program also is doing a good job.

KCMS members meet the second Monday of each month, October through May, for a luncheon with area legislators. They've been meeting for 10 years and have made their luncheons a well-established tradition. Attendance of legislators has been consistently good, according to William McClimans, KCMS executive secretary, and the physicians have accepted the luncheons well. Dale Kessler, MD, is chairman of the legislative meetings.

"Our meetings have fostered real understanding and good relationships," concurs Thomas Berglund, MD, Portage, of the Kalamazoo Academy of Medicine. The Academy holds 7 a.m. breakfast meetings five times each year with local legislators. B. David Wilson, MD, Kalamazoo, is the current chairman of the meetings, which have created "good dialogue between doctors and representatives," according to Doctor Berglund.

Ingham County physicians meet monthly for luncheon on the fourth Thursday of the month, January-May, and once again in October. The ICMS meetings, handy to the Capitol Building, sometimes have registered 100% attendance by area lawmakers. The Ingham meetings consist of discussion of a chosen topic or bill by a physician or legislator, followed by a dialogue on the merits of the proposal or issue.

Another component society active with its legislators is the Ottawa County Medical Society, which has held three Monday morning legislative breakfasts. This group has included county chambers of commerce for the advantage of dialogue between medicine, business and legislators.

"Getting the legislators' trust is the big thing," says Doctor Rapport. "You must make it obvious that the meetings are an effort to inform, not brainwash. Then you can call on the legislators when you need to."

Doctor Wacker's Ingham committee in June analyzed the impact its meetings have had during the past year.

"It's important that we are not simply extending 'the old locker-room,' " he comments, "meeting for a nice lunch and a good talk among ourselves. Unless you can bring in the political people that can have an impact on legislation, you wind up with a big 'so what.' "

The Ingham meetings have been addressed by legislators, attorneys and big business representatives this year. "It's amazing how readily they come in to talk to physicians and legislators," Doctor Wacker comments.

But the Ingham group now favors an attempt to have individual members personally pick up designated lawmakers to drive them to the meetings, ensuring that the needed personnel are present.

As they strive for more effectiveness, Doctor Rapport calls the legislative meetings "really the only way I know of for us to have something to say about legislation. Once we get to know these guys we've got the ballgame licked."

Here's a review of MSMS record in legislature surveillance and action

By Thomas R. Berglund, MD Chairman, MSMS Committee on State Legislation

The Michigan State Medical Society has a long history of monitoring legislation both in Lansing and in Washington. The scope of this short article will have to restrict itself basically to the happenings in Lansing.

One of the lines of the Jaycee Creed reads "We believe that government should be of laws rather than of men." (Richard Nixon tried to change this whole concept and you know what happened to him.) Many physicians will say that if that quote is right, we certainly are being over-governed. That may be so because there are an awful lot of laws that are passed which affect you as a physician and your patients and how they are cared for. Other laws are passed that directly affect the organization of medicine in general.

I would like to briefly spell out the

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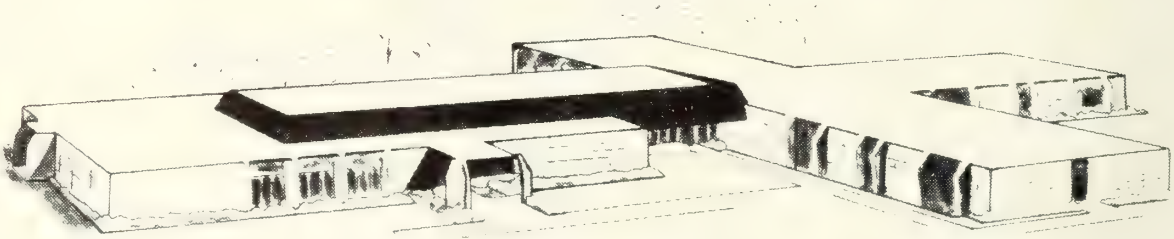

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organization of MSMS, how it operates to take a position on a given piece of legislation; what pieces of legislation are monitored, some specific examples of laws that have been passed that affect physicians and their patients and some of the coming issues.

MSMS has over the years developed a position on a variety of issues based on House of Delegates action. This is the basis for the MSMS stand on many pieces of legislation. In between meetings of the House of Delegates, the Council makes the final decision on what stand MSMS is to take. The Council usually refers for discussion and recommendation any new subject to the Committee on State Legislation and Regulations, which then discusses this, researches it if necessary and finally makes a recommendation to the Council as to what stand MSMS should take. Council then discusses this in its Legislative Policy Committee meeting and then takes a stand. Once MSMS makes a position on a piece of legislation before House or Senate, our lobbyist can then go to work to attempt to get it passed or defeated.

As chairman of the Committee on State Legislation and Regulations, I would like to say a word or two about our committee. The Committee is composed of doctors of medicine from every area and many specialties. These men are dedicated volunteers who come to MSMS five or six times a year at their own expense, taking hours away from their own practice to serve MSMS. The guiding principle by which their decisions are made is, "What is best for the patient?" I am proud to serve as chairman of this committee and proud to have these dedicated members of MSMS serve with me.

No committee could get along at all without staff help. MSMS has, as far as I am concerned, the most dedicated staff any organization could possibly have. Bruce Ambrose is manager of the Department of Government Relations and there is no way possible that we could have anyone better qualified in that position. Bruce is well-known and respected among the legislators in the Capitol, he knows the governmental process well, and has the best interest of the doctors at heart.

When MSMS reorganized the Department of Government Relations two years ago, we recognized the fact that once the laws were made, the bureaucrats took over and implemented the laws, perpetrating many regulations. When we changed the committee from the old Legal Affairs Committee to the present Committee on State Legislation and Regulations, we created a position of Government Agency Liaison Person. Sherry Wellman took this position and has been invaluable in her contact with and surveillance over government agencies. Our present lobbyist, former State Senator Milton Zaagman, likewise does a terrific job and gives us the perspective of an "insider."

Now, I would like to get into some specific areas of legislation from the past and the future. I will not mention the 13 bills regarding professional liability that were passed last year, nor the legislative goals concerning professional liability that we have coming up, as they have been written about in previous issues and all should be quite familiar with them. Suffice it to say that our Committee on State Legislation and Regulations does not feel that the professional liability crisis is passed and much more work needs to be done in this area.

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One of the major issues that your committee worked on diligently and finally became law on January 8, 1974, was the new revised Medical Practice Act. The bill was a joint effort of MSMS and the Medical Practice Board and replaces the old Act of 1899. Many of the other professions now are following our lead and revising their licensing acts. It is a source of pride to those of us involved that they are even copying much of the language verbatim from our Act.

A couple of bills that MSMS was instrumental in getting passed sometime back were the bill which mandates that all plate glass be safety plate glass and another bill which provides that all paint sold shall be free of lead.

A couple of years ago, the Transplantation Society of Michigan sent us a copy of a "Definition of Death Bill." We had this introduced and the Michigan Catholic Conference blew it apart. Through the efforts of Joseph Kincaid, MD, of Kalamazoo, who had written a definition of death for Borgess Hospital, we were able to assist Representative Joyce Simons in writing a bill which has now been passed and signed, and serves as a model for the rest of the country.

Another bill which we were not successful in defeating and was passed despite our objection was the new Generic Drug Act. By House of Delegates resolution, MSMS is opposed to generic drug substitution by pharmacists. We opposed the Generic Substitution Bill and when it was evident that a bill was going to be passed we were able to get changes in the bill which made it more desirable than previously. I should add that at the present time, there is a bill before the Legislature which would extend the Generic Bill and allow pharmacists to substitute without the knowledge of the patient. We are continuing to monitor this bill.

My last specific example of a bill that your committee worked on was House Bill 4804. This bill would have provided for two additional lay persons on the board and would have created a file on each doctor to be reviewed annually by the Medical Practice Act and would have directed the legislature to budget specific amounts of money to the Medical Practice Board. MSMS opposed this bill, not because of the two additional lay persons on the board but because of the bureaucratic nightmare it would have created. This bill was passed by the Senate and the House and vetoed by the Governor. We commended the Governor for his action in vetoing this bill. Since this was a Physicians' Crisis Committee bill, we are now working with the PCC to see if we can't get some type of a compromise bill which is acceptable to both groups introduced and passed.

I could go on with specific examples of bills from the past or bills from the present that affect medicine. A few examples of areas of future concern are regionalization of medical care including emergency medical systems, licensing of emergency medical technicians and advanced emergency medical technicians, extension of the Chiropractic Practice Act, school of optometry at Ferris, licensing of physician's assistants, a multitude of anti-smoking bills, many bills dealing with abortions, licensing of medical laboratories and the list goes on.

What does the future hold in store for us? I don't think there is any question that we are going to continue to have laws introduced and passed and the governmental influence on medicine will be greater than it is at present. Our goal is to make it workable and in the best interest of our patients. Significant upcoming bills include the Public Health Statute Revision Project. Our committee had a subcommittee chaired by Jim Read, MD, who did an absolutely fantastic job with the help of staff person Sherry Wellman. The subcommittee waded through well over 200 specific recommendations. MSMS is in favor of this project but has some specific objections which we are attempting to change. This project will completely reorganize the department of public health.

Another study that is underway is to change the licensure laws of the State of Michigan. I think that some time in the future we will see licenses issued for a restricted period of time and some type of retesting for relicensure at given intervals will be necessary.

One of our top priorities for the upcoming year will be the Malpractice Procedures Improvement Act. This is a bill which is jointly introduced by the Michigan Hospital Association and MSMS which will deal with several of the professional liability areas including attempts to differentiate maloccurrence or undesirable results from malpractice.

Thus, you can see that the job of monitoring state legislation is a continuous job and one that affects all of us. The Michigan State Medical Society continues to attempt to have a position which is in the best interest of our patients and protects the private practice of medicine.

Michigan experience surpasses Illinois' in malpractice laws

There is new proof that the members of the MSMS Committee on State Legislation, do their homework carefully . . .

In exploring various solutions to the complex medical professional liability situation, MSMS committee members and Councilors in 1975 tried to anticipate what solutions would best hold up in the courts.

All the legislation adopted in 1976 by the Michigan Legislature, at the urging of MSMS, is still intact. While relief has not come as quickly as doctors had hoped, the laws are on the books and there are new procedures and practices in effect.

Contrast this to the Illinois situation. The *American Medical News* reports that the Illinois State Supreme Court has struck down three of the four malpractice bills adopted by the Illinois legislature. For example, the Illinois Court said the $500,000 cap on awards "was arbitrary and constituted a special privilege." That approach had been considered by Michigan interests, but not pursued.

The Doctor of the Week as legislator sees program

By Senator Anthony A. Derezinski (D-Muskegon)

Some people wonder why we bother with programs such as the MSMS Doctor of the Week series here in the legislature. To those people I have one simple answer; we might as well ask why we bother with any kind of citizen input to the legislature; why bother being interested in the opinions, views, ideas or interests of any particular professional or citizen group in our district?

The obvious fact is that the Doctor of the Week program serves an excellent purpose.

Each week a local Michigan physician gets the opportunity to meet and talk directly with his or her local legislators. As physicians and citizens they are able to observe the intricate legislative process which, I believe, allows them to gain firsthand a direct respect for the complexities of passing legislation, especially technical legislation such as that affecting health care in Michigan.

Sen. Derezinski

In addition, of course, the doctors and their local legislators have an opportunity to exchange directly, over an extended period of time, ideas on legislation affecting both the medical profession and health care in general.

Finally, Michigan physicians are able to observe firsthand how their local representatives deal with the political process which often involves compromise and great cooperation between legislators of widely differing philosophies.

Quite frankly, this last point was one that I learned to appreciate only after dealing with legislative situations directly. This kind of an "education" only can be gained by coming to Lansing and observing and participating in the process.

Why are all of these positive features of the Doctor of the Week program important? Simply because legislation is not made in a vacuum. Everyone must learn that input on laws needs to come before bills are introduced and certainly before they reach the final testing stages on the floor of the state legislature. Moreover, the public must learn what types of information can be most useful in influencing the passage of bills.

A lobbyist is charged with guiding specific legislative policies. The lobbyist, however, is most likely not a constituent and it is probably more important for legislators to know how the physician in their district feels about a specific medical practice or public health bill than to hear the official policy of an organization from its lobbyist.

The Doctor of the Week program allows your local legislator to discuss informally, issues involving all of the people in his or her particular district. Doctors are in a unique position because they see so many different people in their area. Thus, they have a feel not just for public health problems, but also for many other community issues. Generally, physicians are actively involved in their communities. The Doctor of the Week program enables state legislators to gain valuable information about a wide variety of issues confronting localities outside of the medical field. Even though each legislator sits on several committees and makes decisions that affect the entire state, we have to make every effort to remain up to date on what is happening in our local communities.

It all boils down to a question of communication. We learn much about the special problems of physicians and health care services in our districts. In addition we are able to discuss with you, specifically, problems of our area communities. In turn we provide local medical professionals with an active, straightforward look at the political process and how legislation is guided through that process. I believe that both the physicians and the legislators involved gain a great deal from the program.

No political or legislative decision is ever made in a vacuum, but most people, even professionals, believe that the legislative process is complicated. They refuse to become involved in the communication process with their legislators. The Doctor of the Week soon learns that such an exchange is absolutely necessary. Once the process is learned and developed, everyone gains.

MSMS governmental staff serves physicians many ways

Physician views and interests in government are represented day-to-day in Lansing by the MSMS Department of Government Relations.

The department meets with legislators, seeks to influence development and progress of legislation, monitors and consults with government departments, bureaus and agencies, assists the AMA on national legislation, and helps coordinate Michigan physicians' political activities.

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Formulating guidelines for the department's staff of four persons and one independent consultant are four key MSMS committees: The Committee on State Legislation and Regulations, (Thomas R. Berglund, MD, chairman), the Committee on Federal Legislation, (Robert C. Rice, MD, chairman), the Medical Liaison Committee, (David Siegel, MD, chairman), and the Committee on Liaison with the Medical Practice Board, (Robert M. Stow, MD, chairman). Decisions and directives of these committees are screened through The Council's reference committee on Legislative Policy and finally through the full Council.

Department staff consists of Bruce Ambrose, manager; Sherry Wellman, staff assistant for government agency liaison; John Richards, staff assistant for political action, and Lenora Evey, departmental secretary. Additionally, the MSMS legislative effort is assisted by independent legislative consultant Milton Zaagman, whose primary client is MSMS.

The present government relations staff structure has been in effect since the MSMS House of Delegates in 1973 authorized an increase in personnel to meet the growing demands of the department. The department's contacts have grown explosively among government agencies — Medicaid, Public Health, state health planning — and the House of Delegates action was designed particularly to enhance that facet of MSMS liaison.

"We simply were unable to keep up with the vast increases in employes in the health sector of government without a liaison person assigned to that task alone," explains Mr. Ambrose. "So much work is initiated in this area of government, that constant liaison has become an absolute necessity."

"Our agency liaison successes have been so obvious," says Mr. Ambrose, "that other organizations (Michigan Hospital Association and Michigan Dental Association) are tracking the same course by designating people to the same kinds of responsibilities."

Successful endeavors of the government liaison program, Ambrose noted, are MSMS modifications to the proposed new state public health code and the more visible ongoing work with the MSMS Medicaid Liaison Committee.

"Many of the objections we could have had to the final PHSRP report were ameliorated in development through the efforts of the physicians involved and staff. Physicians from MSMS were effective both as members of the PHSRP project (Addison Prince, MD, Detroit, and Robert J. Toteff, MD, Saginaw) and through the MSMS Ad Hoc Task Force (James A. Read, MD, Birmingham, chairman.)

The work of the Medicaid Liaison Committee is well known. Organized in 1973 to provide an instant flow of physician frustrations to the department of social services, the committee has successfully resolved many minor issues before they became major problems, Mr. Ambrose believes. "Irritation and stress between physician providers of service and the Medicaid program is an ongoing thing, and will always be with us," he said. "The Medicaid Liaison Committee provides the arena in which to deal with those tensions."

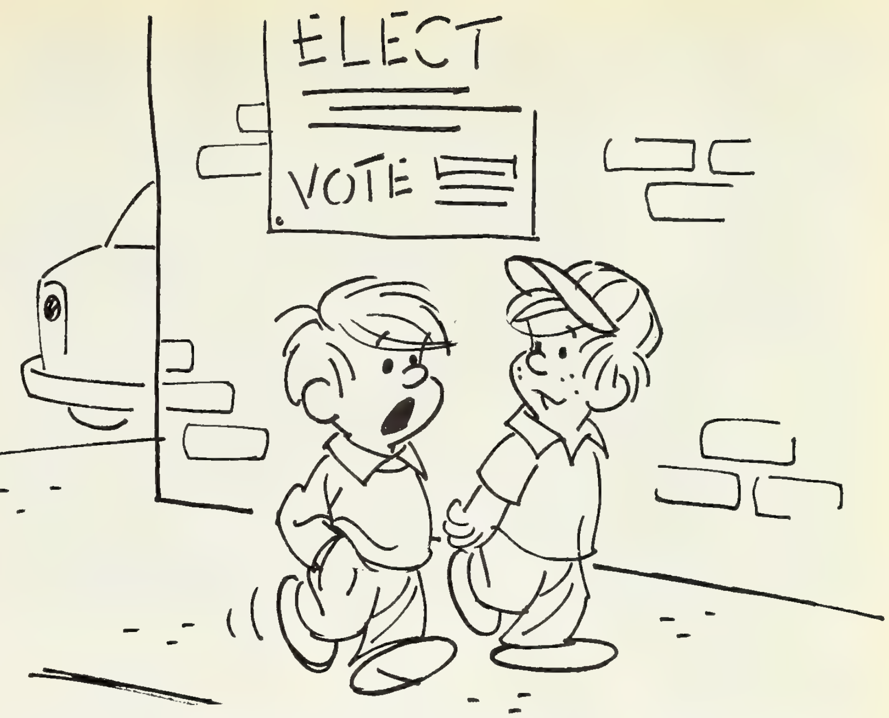
Legislative liaison has improved, Mr. Ambrose believes, by centralizing that function through Zaagman Associates, a Lansing-based independent legislative consulting firm. Mr. Zaagman spent one year as an MSMS employe following 12 years in the Michigan Senate. He then organized his independent consulting firm with MSMS his primary client.

"While MSMS is credited mostly with its work in the last two years on medical malpractice legislation, the work of the legislative liaison goes far beyond that. MSMS has influenced legislation regarding determination of death, reasonable constraints on generic drug substitution, removal of nuclear medicine from radioactive waste legislation, and several other bills, as well as appropriations to the departments of public health, mental health and licensing and regulations.

Legislative work is supported by the ongoing Doctor-of-the-Week program, which in 1976 has involved 18 physicians from all over Michigan. John Richards is staff person in charge of this unusual program which has been copied or adapted in several states. (See article on page 381 by State Sen. Anthony Derezinski (D-Muskegon.)

Mr. Richards also serves as consultant to the Michigan Doctors Political Action Committee, which is a free-standing adjunct to MSMS in partisan politics.

Mr. Ambrose himself oversees departmental activities, continues his own contacts in the Lansing Capitol and with government officials, staffs the MSMS committees on state and federal legislation, and monitors and assists the AMA upon request on federal legislation.



"I wouldn't want to be elected president. I get blamed enough for things as it is."

"The MSMS Committee on Federal Legislation views its charge as one of advising the state's physicians on the ramifications and impact of federal legislation, when it is implemented," he says. "Whereas the AMA often seeks state society assistance in contacting congressional figures, the committee's main thrust is to assist Michigan physicians in grappling with federal laws, rules and regulations."

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MSMS has a growing responsibility to participate in the rule-making process. In the past, the society has made repeated requests, and even some demands, that state agencies seek comments from MSMS before processing rules on health issues. As mentioned earlier, those requests are being met with increasing frequency.

MSMS is being asked to serve on task forces, commissions and councils of state agencies drafting rules. Huge draft documents are sent to MSMS with a request for comments and suggestions. As the issues become more medically specific and complex, MSMS physicians will be asked to share the responsibility of responding to the proposals.

We have asked for the opportunity to play a significant role in rule-making; we must be prepared to meet the responsibility.

The following article describes MSMS growth in recent years in the state health rules-making procedure, and presents some challenges which lie ahead in the field.

Robert M. Leitch, MD
MSMS President

MSMS expanding its liaison with governmental bodies

By Sherry Wellman
MSMS Government Agency Liaison

Virtually every piece of state and federal legislation contains general language similar to the following: "The department (director, agency, office, board) may promulgate such rules as may be necessary to carry out the purposes and enforce the provisions of this act."

Sometimes the language is quite specific, as in, "The department shall promulgate rules to differentiate a freestanding surgical outpatient facility from a private office of a practicing physician, dentist, podiatrist, or other private practice office."

There are several reasons for the provision for rule-making after legislation becomes law. For one thing, statutes are much more difficult to change than are rules and therefore cannot adapt to meet current situations and needs. A good example would be the antiquated public health statutes still on the books appropriating funds to non-existent TB sanatoria. Additionally, legislators have tended to draft laws spelling out the broad purposes while designating a department or agency to fill in the details by rule-making.

Bureaucracy: a government or other organization characterized by specialization of functions, adherence to fixed rules, and a hierarchy of authority; a system of administration marked by officialism, red tape and proliferation. (From *Webster's New Collegiate Dictionary.*)

Regulation: the intervention of government in the health care or health insurance market to control entry into, or change the behavior of participants in, that marketplace through specification of rules for the participants. Regulatory programs can be described in terms of their purpose (control charges), who is regulated (hospitals), who regulates (state government), and method (prospective rate review). Also a synonym for a rule published by the executive branch of government implementing a law. (From *A Discursive Dictionary of Health Care,* U.S. Government Printing Office.)

Rule: in the executive branch of government, an agency statement of general or particular applicability and future effect designed to implement interpret or prescribe law or policy, or describing the organization, procedure or practice requirements of an agency. Commonly also called a regulation. The process of writing a rule is called a rule-making. A rule, once adopted in accordance with the procedures specified in the Administrative Procedures Act, has the force of law. (From *A Discursive Dictionary of Health Care,* U.S. Government Printing Office.)

Rule-making is advantageous because of its greater flexibility than statute, but rule-making has come under criticism and scrutiny because of its proliferation, and in some cases, abuse. The fact that rules have the effect of law; that they are seldom subject to close legislative and public review; that they are promoted by nameless figures in the bureaucracy, as well as the sheer number of rules promulgated annually make the process worthy of consideration.

In recent years, the health care sector has become increasingly aware of the effect that rules and regulations have on the practice of medicine. HEW has demonstrated a fondness for publishing proposed rules in the *Federal Register,* hoping that no one will notice them within the 30 day review and comment period, and thereby establishing laws which at times seem far removed from the intent of the original legislation enacted by Congress.

On the state level, the public does not even have the benefit of reviewing proposed rules in a publication similar to the *Federal Register.* In Michigan, the average citizen must rely on the ability to catch an announcement in a newspaper that a particular state department intends to process a set of rules. If a person desires information on the rules, a copy can be requested from the department and comments can be submitted to the department and to the Joint Administrative Rules Committee of the Legislature. Public participation hinges on reading the newspaper thoroughly.

In 1974, the MSMS House of Delegates approved a recommendation to expand the Department of Government Relations in order to establish full-time surveillance of government agencies and the rule-making process as they affected the health care sector. The delegates recognized that effective government liaison could not be concentrated solely on the legislative process, because in many cases legislation is only the tip of the iceberg.

In the last two years, MSMS has seen substantial progress in improving its liaison with government agencies. It must be noted that many state agencies welcomed a new formalized avenue through which they could obtain advice and comments from the medical profession. MSMS has ongoing liaison with the Department of Public Health, the Department of Social Services, the Department of Mental Health, the Department of Licensing and Regulation (Medical Practice Board), and Office of Health and Medical Affairs and other departments on specific projects.

Through both formal and informal communications, MSMS now receives advance copies of health-related rules being processed by a department or agency. Our comments are often solicited in the early draft stages, prior to the final proposal. MSMS is apprised in advance of public hearings and consideration by the Joint Administrative Rules Committee and invited to submit comments. Yet there is much to be done.

The 1976 MSMS House of Delegates directed MSMS to work with other associations and consumer groups to open the bureaucratic rule-making process to greater public review.

There are a number of interesting possibilities to spark discussion. One would be the publication of a bulletin of proposed rules, similar to the *Federal Register,* which at least would be better than the present newspaper notice system. Another would be to increase the review and comment period to give greater opportunity to more sectors of the public. Recently introduced in the Michigan Legislature is the concept of "Sunset Laws" which terminates existence of special purpose agencies after a given number of years unless they can demonstrate the need for their continuation. Of particular interest to Medicaid providers could be an inquiry as to why regulations issued as Medical Assistance Program Bulletins are not subject to any formal review when all other agency rules and regulations must undergo the process of the Administrative Procedures Act. These and other issues will certainly be discussed on both the federal and state levels.

Add clout to MDPAC – contribute your $25 now

By Vernon V. Bass, MD
MDPAC Past Chairman

A successful political action program must have many ingredients. Among these are grassroots interest in the political process, professional representation before government bodies, personal support of friendly candidates and a strong and active political action committee.

Grassroots interest is the first requirement for a good political process. After all, politics is only directed self-interest. Without a group of politically active people, any political action program will be a failure.

Another ingredient for a successful political action program is a strong political action committee. By strong, we mean a well-funded committee with representatives in each part of the state, willing to communicate with the PAC's board regarding which candidate needs and deserves support.

Michigan doctors do have a strong political action committee — MDPAC — but it could be much stronger.

MDPAC and its clout

MDPAC is a bi-partisan committee that accepts contributions from doctors, their spouses and any other friend of medicine, and uses the money to contribute to the campaigns of politicians. This committee is run by a board of directors made up of representatives from each congressional district, plus representatives from the MSMS Council and the Auxiliary.

The most convenient way that a doctor can contribute to MDPAC is to simply make a donation along with dues as provided for on the billing form.

During election, the MDPAC board meets regularly to decide how the money should be distributed. Part of each contribution is used to purchase membership in AMPAC (the American Medical Political Committee). This committee functions in the same way as MDPAC but on the federal level. Its board is selected on a regional basis. MDPAC can also make contributions on the federal level. This means that a deserving candidate can receive two contributions from physician political action committees.

With the new federal election law, political action committees are now in a much stronger position to make contributions. Formerly a politician had to depend on a few individuals or committees to make the majority of his contributions.

The new law sets a specific limit to how much an individual can give to any one politician. Political action committees also have a limit. However, where an individual is limited to an absolute of $1,000 per election per candidate, a political action committee can make a contribution of $5,000. As you can see, the difference in limits can give political action committees a lot of leverage in the campaign.

It has been said that politics is something that everybody is interested in — at the wrong time. Sure, it's easy right now to be interested in the presidential primary, or the Michigan senatorial race, because the elections are only weeks away. But MDPAC has been working for two years with candidates and legislators in order to get a clear picture of how they view medicine and who deserves support.

Doctors should contribute

Why should the doctor give money to MDPAC, especially if s/he is actively supporting a candidate? Because, MDPAC supports candidates from all over the state. It is especially important to have friends in all districts of the state, not just in ones that have a concentration of active doctors.

The board of directors of MDPAC makes decisions regarding contributions to political campaigns using a number of criteria. One of these is how much local support a candidate has from the doctors in his district. If you know of a candidate that you think is deserving of support, then by all means let a member of the PAC board of directors know about the individual.

Remember, that many of the other groups in this state are taking a vital interest in who gets elected. In 1974 the UAW's Community Action Program (CAP) Region V, which principally includes Michigan, contributed $839,205.60 to candidates. MDPAC contributed $47,741.83 — completely depleting its coffer in the process.

It is still amazing that with all the legislation affecting medicine in the past few years, only one of every four doctors in this state contributes to the PAC.

As you can see from the above figure, the UAW is well aware of the need for a strong political action committee. If every doctor in this state made a $25 contribution, it would mean that we could have much more influence in who gets elected.

If you already have contributed to MDPAC — thank you! You have already done much to help yourself and your profession. If you have not contributed to the race, please do so as the election is not far away. Your $25 contribution is only 50 cents a week; but it can mean, when added together with the rest of your colleagues' donations, a difference in the type of person who will be representing you in the future.

Send your contributions to: MDPAC — % John Richards, P.O. Box 769, East Lansing, Michigan 48823.

ELECTION POLL

"Just a simple 'yes' or 'no' if you please, sir."

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain for the pathogens

☐ **Early relief of painful symptoms** such as burning and discomfort associated with urgency and frequency.

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

ROCHE

DYAZIDE®
Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*

LOWERS
BLOOD
PRESSURE
CONSERVES
POTASSIUM

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
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The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.

J-4837-4

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When Big Ben looks "a little off."...

Antivert®/25
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for vertigo*

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Do left handed doctors really have more fun?

By C. R. Shelton
Special to Michigan Medicine

Few things are so heady for a freelance writer as an assignment from a journal such as MICHIGAN MEDICINE, especially when it calls for an article that has possibilities of being an exposé, or at the very least a real "inside" piece on people who have some unique qualities.

What of the problems of a left-handed physician?

Visions of cool titles dance before the typewriter such as "Inside The Left-Handed Doctor," or "Everything You Have Always Wanted To Know About Your Left-Handed Doctor But Been Afraid To Ask," or maybe even "Deep Lefty." — No, I think not.

Quick calls go out to the ever-helpful Jane Blue, MD, who knows everybody as well as what hand he or she prefers. This is followed by conversations on the subject with physicians who are personal friends, and the loan of an impressive publication, "Research Monographs No. 5, The Master Hand," published by the American Orthopsychiatric Association, Inc.

Next come visits to libraries, medical and other, where we may turn up tidbits of exciting information — that no one knows, or maybe even cares about, except the person who wrote the monograph, article or book.

The first victim

By now we can hardly wait to encounter one of those left-handed doctors, for we are sure to uncover undreamed-of hidden evidence of who-knows-what.

First blood! An interview appointment with perhaps the dean of left-handed doctors in Michigan, who is nothing less than a surgeon.

Yet all appears to be "normal" and the man acts no differently from other people except he is one of the most courteous and friendly MD's we've come across.

The "shocking truth" learned during that and subsequent interviews is that left-handed physicians differ very little from their right-handed colleagues.

The majority of left-handed physicians we interviewed have trained themselves to be ambidextrous. While their left hand may still be dominant in everyday activities such as eating and tying shoe laces, they consider their hand preference no problem, and report they had little difficulty adjusting to the right-handed world of medical school.

A few of the surgeons we talked with use left-handed surgical instruments, but such instruments are not readily available and most use the ones made for the right hand.

However, a left-handed surgeon probably gives closer attention to needle holders than do other surgeons, and usually can tie both left-handed and right-handed knots. Unless they have left-handed scissors, most cut with their right hand (to understand why, if you are right-handed, take a pair of ordinary scissors in your left hand and try cutting a piece of paper in a straight line.)

During some surgical procedures — certain abdominal ones in particular — being left-handed can prove beneficial. Also, when a left-handed and a right-handed surgeon operate together, both can benefit because each can stand on the side of the table most comfortable for him.

More MDs are left-handed

Approximately one person in 10 is left-handed. Reliable sources estimate that the percentage of left-handed persons in MD ranks is greater than in most other professions (professional baseball may be an exception). Definitive reasons why this is so appear not to exist, though many believe that left-handers tend to be more highly motivated than their right-handed peers.

But what of the future for left-handed people in medicine?

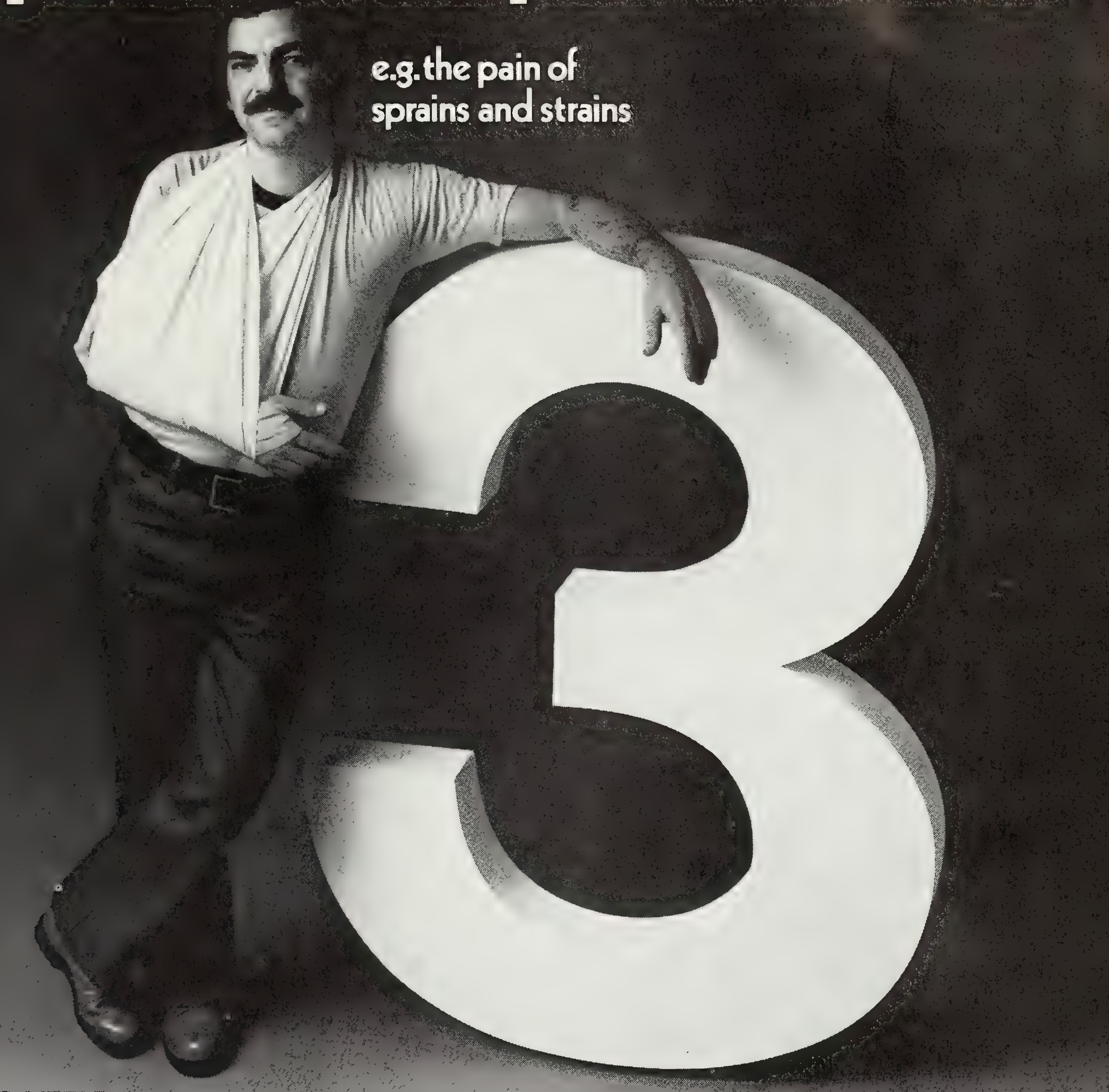
When we asked if they have any advice to offer left-handed youths who want to study medicine, none of our left-handed interviewees suggested a change of plans because of the adjustments that will be required, nor do they suggest trying to change to the point of becoming right-handed.

Well, is there no mystery, no intrigue, no psyche-shaking problems in the part of medicine (we interviewed physicians in specialties other than surgery) occupied by left-handed doctors? Apparently not, just highly competent, hard working people dedicated to their profession.

So much for Watergate-type investigative reporting this time.

Ms. Editor: Perhaps we could uncover more differences among doctors who drink tea instead of coffee, bourbon instead of scotch, or who drive VW's instead of Cadillacs? Exposé possibilities seem endless.

No. 3
As potent as the pain it relieves.



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North Carolina 27709

Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

LETTERS

What if you could not vote?

Can you imagine a presidential election day in America when nobody goes to the polls?

That is how the 1976 election will seem in my town. And, judging all by the 300 whom I interviewed, most of my 3,700 townsmen are chronic misfits who couldn't care less. Yet some squared off and swung verbal blows at voter apathy — all in response to my question: "Did you vote in seventy-two?"

Hopefully, no blow will hit you . . . unless deservedly.

Joe had gambling syndicate connections. "The organization always saw to it that I voted; even told me who and what to vote for," he said. "Apathy is a cardinal no-no among underworld professionals and they leave no underling unregistered or uninformed at election time. What price apathy? My underworld boss had a relevant sign hanging in his office. Titled *Little By Little,* it read: *As inflation attacks our incomes today apathy imperils The American Way.*"

Recidivist Al was sullen and uncompromising. "You kiddin'?" he growled. "I never voted in my life! I've got sense enough to know no matter who gets elected the best most breadwinners are gonna get is the worst of it — probably because a desperate one third of 'em are too busy flunkyin' out an existence to face up to apathy. Or maybe they're just disgusted, like me. I don't vote because no way do I wanna feel responsible for the stinkin' shenanigans that keep comin' off in politics! It's bad enough bein' a burglar!"

Harry claims that betting on racehorses is in his blood. One day, up tight for track money, he got caught trying to hold up a bank. "Yeah, I voted in '72," he said. "George got my vote because McGovern was the name of a cop who gave me a break when I was a kid. And this bugged me later as I recalled the time I'd spent with *Daily Racing Forms,* thoroughly checking performance records of the nags I'd put my money on. The folly of my reason for choosing George finally came into focus with this realization: We lay more than mere money on the line when we go to the polls and discharge our basic obligation to liberty."

Perry is a *Chippewa* who got too full of firewater one night and was out shooting up his hometown when a ricocheting bullet struck and killed a passerby. "But I never got too drunk to vote," he said. "In fact — well, you've seen that TV Indian with a tear streaking his cheek as he surveys what modern Americans have done to America. That's the way I feel when people who claim to love their country stay away from the polls in droves. Makes me wonder."

What price apathy? Perry put it ecologically: "Whatever the price, eventually it must be paid in full because apathy is no less a corrupting agent than any other kind of pollution."

Perry's blow hit me. I have found it convenient to take my country for granted. Though I am aware that the bell cords which keep freedom ringing are in the ballot box and that the bell my vote rings is as loud, clear and vital as any American's, I have often failed to vote simply because there were other things to do. Yet, typical of now-and-then and nonvoters, I am seldom apathetic when it comes to complaining.

What price apathy? If not appalling, it is sufficiently dear to alarm any American who is not hung up on so-what-ism.

But none of my townspeople will vote in this Bicentennial Presidential Election Year. All have been stripped of voting rights. So have I.

I live in "Jacktown" — Southern Michigan Prison, near Jackson.

Patriotically, from my vantage point, the only place worse is your town, where each and every adult citizen *may* vote . . .

And you don't.

Pete Simer
87776 PO Box E
Jackson, 49204

Pathologists offer tapes of seminars

Kodachromes, protocols, diagnoses, and discussion of 12 cases of "Forensic Pathology Potpourri" are available to non-members of Michigan Society of Pathologists for $15 per set.

Discussants of the seminar given May 8, 1976 at Michigan State University were Werner Spitz, MD, medical examiner, Wayne County; Robert Hendrix, MD, University of Michigan; Willys Mueller, MD, Hurley Hospital, Flint.

Address inquiries and checks to Michigan Society of Pathologists, John F. Dunkel, MD, secretary-treasurer, Department of Pathology, 622 E. Fee Hall, Michigan State University, E. Lansing, 48824.

Other seminar sets still available at $15 each:

"Problems in Viral Hepatitis," discussants, Henry D. Appelman, MD, and Keith S. Henley, University of Michigan, May, 1975.

"Comparative Pathology," May, 1972, discussant, Lt. Col. Robert M. McCully.

"Acht Kleine Houlstricke," December, 1975, (Eight Little Pieces of Skin) John T. Headington, MD, University of Michigan, discussant.

Sincerely,
John F. Dunkel, MD
Secretary-Treasurer, MSP

HEW has an opening in Boise

The Department of Health and Welfare currently has an opening in Boise for a director of preventive medicine who will be responsible for establishing policies, developing, organizing and administering a statewide coordinated program of preventive medical services and coordinating the activities of the Preventive Medicine Section with other sections in the Department and local health units. The examination process for this position is 100% evaluation of credentials.

Starting salary for the Director of Preventive Medicine is $2,336/mo plus a liberal fringe benefit program. Minimum qualifications required are:

1. A degree of Doctor of Medicine from a medical school of recognized standing. Eligibility for examination for medical licensure in Idaho, which includes one year's internship in a hospital of recognized standing (license to be secured upon appointment); one year's graduate study at a school of public health of recognized standing; three year's experience in full-time public health service, two years of which shall have been in an administrative or supervisory capacity.

2. Thorough knowledge of the principles and practices of public health administration; wide knowledge of the principles and practices of modern medicine; wide knowledge of methods used in the control of preventable diseases; knowledge of maternal and child health and crippled children's programs, of industrial health, public health nursing and oral health programs; general knowledge of the functions and purposes of a state level health department and the administrative practices of federal, state and local health agencies.

3. Ability to direct the work of the Preventive Medicine Section and to establish and maintain cooperative relationships.

Anyone qualifying for and interested in this position should contact me immediately for an application form. Applications will not be accepted after July 30, 1976.

The Department of Health & Welfare is an equal opportunity employer (M/F).

Sincerely,
(Ms.) Judy Aitken
Bureau of Personnel

Virginia Monthly reprints MM article

Just wanted you to know we're reprinting your published pointers on lobbying (*Michigan Medicine,* February, 1976) in the June issue, amongst things legislative.

Many thanks for this copy!

Ann Gray, Managing Editor
Virginia Medical Monthly

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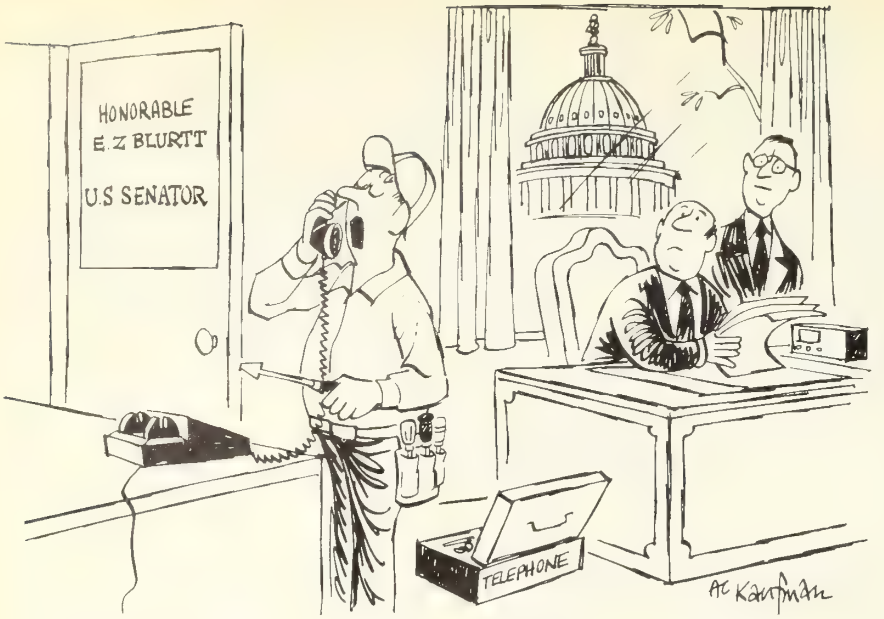


"Testing . . . one billion, two billion, three billion . . ."

Thanks for issue on Michigan Week

The Greater Michigan Foundation appreciates your May issue of Michigan Medicine which effectively brought Michigan Week to the attention of your readers. Many of the physicians could well have missed the special Week if you had not presented same so forcefully.

We did have a good Michigan Week this year. Next year will be even better.

William F. Bresler,
Executive Director
Greater Michigan Foundation

LETTERS/*Continued*

Here's how to contact doctors' AA

In spite of the education and training of doctors, they do become "alcoholics," even though they may never see skid row. Alcoholism appears to happen to people who do not want it — even doctors.

Because of the fact that there undoubtedly are alcoholics among your membership, we would like them to know about:

> International Doctors in Alcoholics Anonymous. IDAA is a non-dues-paying organization of physicians and dentists who get together at least yearly to help each other obtain and maintain their sobriety and freedom from drugs. The next annual convention will be held at the new Los Angeles Marriott Hotel, August 5-8. Tax deductible. Inquirers and newcomers welcome. For information write: Secretary, IDAA, 1950 Volney, Youngstown, Ohio 44511.

Thank you for this service to your membership.

Sincerely,

Luke Reed, MD
Secretary, IDAA

Maybe older, but not 'venerable'

When 1983 comes around and you announce the 50-year awards, please don't refer to us as "venerable." Older than some of the rest we may be, but venerable we "ain't."

John R. Rodger, MD
U of Michigan '33
Bellaire

MSMS help fantastic!

I called you a few weeks ago asking for information on doctors' malpractice insurance. The information you sent was *fantastic*!

Thank you very much for your help and for taking the time to get that information together for me.

Jane Klassen
Stevensville

P.S. I got an "A" on the paper!

Please contact this doctor about insect bites

Again this year I am compiling a Biting Insect Summary and would appreciate any case reports of unusual allergic reactions, especially systemic (sneezing, wheezing, urticaria) to bites of insects; i.e., mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies.

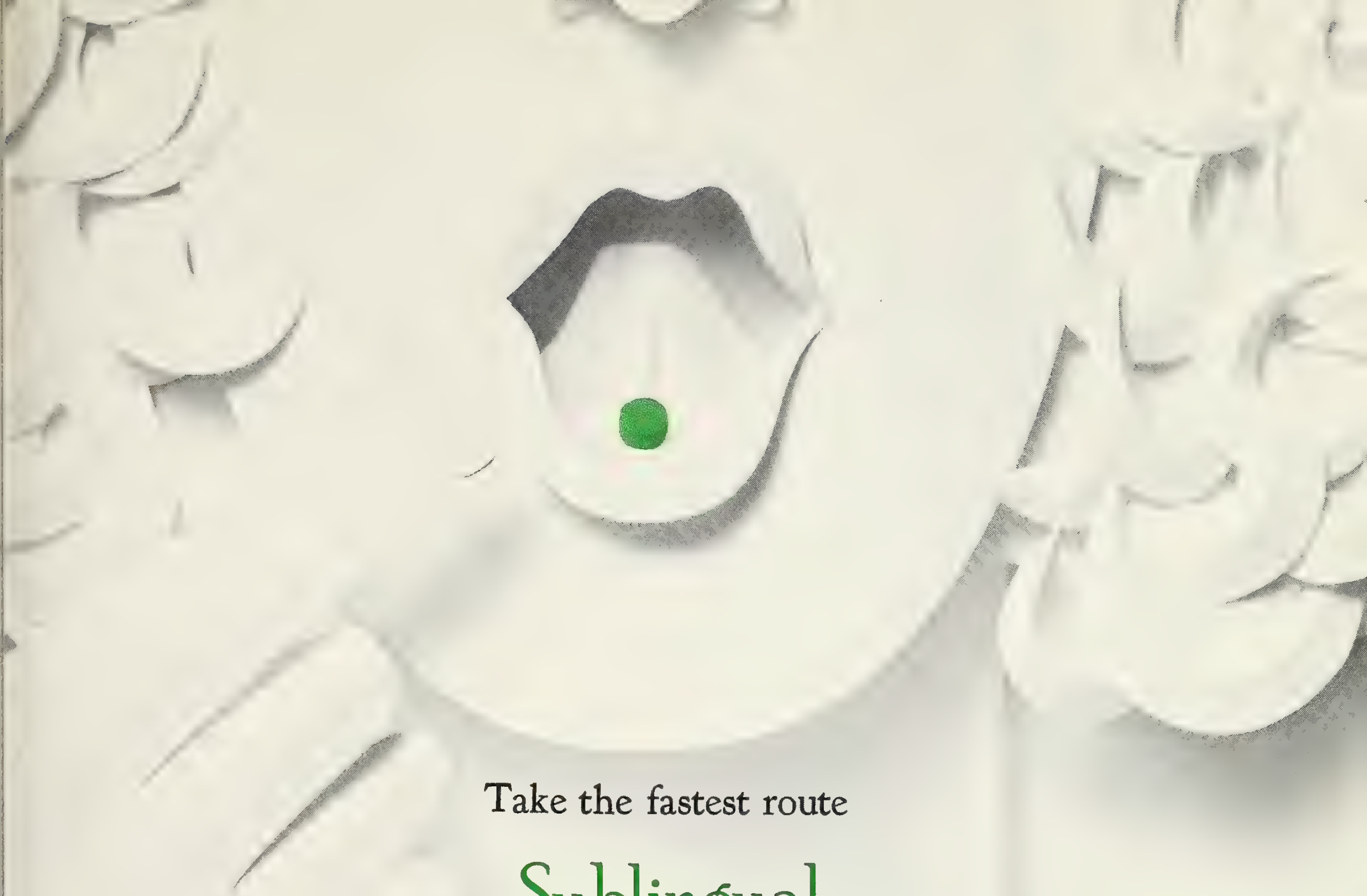
I would like physicians to supply me with case reports of those patients who have had unusual reactions to such insects. Please include the type of reactions (immediate and delayed symptoms), treatment, the age, sex, and race of the patient, the site of the bite(s), the season of the year, and any other associated allergies.

If skin tests and hyposensitization were instituted, I would like the report of both. Please note that it is the biting (not stinging) insect in which I am interested.

If you have found any insect repellent, local treatment, or insecticides of value, I would also appreciate knowing of this.

Please send this information to the following address:

Claude A. Frazier, M.D.
4-C Doctors Park
Asheville, NC 28801



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☐ Proceedings of the Vascular Headache Symposium (Printed)

Patient Information Booklets ☐

☐ Reprint of *Abortive Therapy for Vascular Headaches* (Consultant 16:156-165, 1976)

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1. Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976.

See reverse side for prescribing information.

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Precautions and Contraindications: Avoid prolonged administration or dosage in excess of that recommended because of the danger of ergotism and gangrene. Contraindicated in sepsis, occlusive vascular disease (thromboangiitis obliterans, luetic arteritis, severe arteriosclerosis, coronary artery disease, thrombophlebitis, Raynaud's disease), hepatic disease, renal disease, severe pruritus, and pregnancy.

Side Effects: No serious complications have been reported from the use of Ergomar (ergotamine tartrate) in the absence of contraindications and in recommended dosages. Unpleasant side effects which may occur include nausea and vomiting, weakness in the legs, muscle pains in the extremities, numbness and tingling of fingers and toes, precordial distress and pain, and transient tachycardia or bradycardia. Localized edema and itching may occur in the rare sensitive patient. Side effects are usually not such as to necessitate interruption of therapy.

Administration and Dosage: All efforts should be made to initiate therapy as soon as possible after the first symptoms of the attack are noted, since success is proportional to rapidity of treatment, and lower dosages will be effective. At the first sign of an attack, or to relieve the symptoms of the full-blown attack, one tablet is placed under the tongue. Another tablet should be taken at half-hourly intervals thereafter, if necessary, but dosage must not exceed three tablets in any 24-hour period. Limit dosage to not more than 10 mg. in any one week.

How Supplied: Tablets (green), each containing 2.0 mg. ergotamine tartrate, supplied in units of 12.

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welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Mussarat Abidi, MD
1579 W. Big Beaver Rd. B-6
Troy 48084

Mosharraf U. Ahmed, MD
3140 Summers Rd.
Keego Harbor 48033

Federico A. Arcari, MD
Beaumont Medical Bldg. #506
Royal Oak 48072

Erawati V. Bawle, MD
3800 Woodward Ave.
Detroit 48201

Sidney B. Beck, MD
11885 E. 12 Mile Rd.
Warren 48093

Robert E. Birk, MD
17894 Mack Ave.
Grosse Pointe 48224

Frank N. Burt, MD
15990 W. 9 Mile Rd.
Southfield 48075

John N. Campbell, MD
6185 Scotthille, S.E.
Grand Rapids 49506

Donald W. Cline, MD
7471 Jackson
Birmingham 48010

Frederick L. Cohen, MD
3229 Woodward Ave.
Berkley 48072

David A. Danley, MD
6001 W. Outer Dr. #138
Detroit 48235

Barry L. DeWitt, MD
Hurley Medical Center
Flint 48502

Richard A. Edlund, MD
3535 Park St.
Muskegon 49442

Arthur N. Feinberg, MD
2901 S. Westnedge
Kalamazoo 49008

Shobha S. Gehani, MD
18400 Schaeffer Rd.
Detroit 48237

Jasbir S. Gill, MD
461 W. Huron St.
Pontiac 48053

Alvaro A. Giraldo-Gomez, MD
22101 Moross Rd.
Detroit 48236

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St. Joseph Hosp.
Flint 48502

Raymond F. Hansen, MD
2909 E. Grand River #230
Lansing 48912

Lloyd J. Helder, MD
314 S. Brown
Mt. Pleasant 48858

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SW Medical Clinic
Berrien Springs 49103

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8807 Gull Rd.
Richland 49083

Gary D. Hood, MD
G-5067 W. Bristol Rd.
Flint 48507

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113 E. Williams St.
Owosso 48867

Howard C. Joondeph, MD
15401 E. Jefferson
Grosse Pointe Park 48230

Bernhard A. Kats, MD
A-110 E. Fee Hall-MSU
East Lansing 48824

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401 W. Greenlawn
Lansing 48910

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1634 Gull Rd.
Kalamazoo 49001

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22341 W. Eight Mile Rd.
Detroit 48219

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143 Seminole
Pontiac 48053

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650 Steward Rd.
Monroe 48161

Kamlesh Kumari-Lobo, MD
4184 Shorecrest Dr.
West Bloomfield 48033

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2590 N. Monroe St.
Monroe 48161

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400 Sweet St., N.E.
Grand Rapids 49505

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1326 St. Antoine
Detroit 48226

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Grayling 49738

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Pontiac 48053

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971 Midland Rd.
Saginaw 48603

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Muskegon 49441

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Branch Co. Comm. Hlth. Ctr.
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Parchment 49004

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St. Joseph 49085

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St. Joseph 49085

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St. Joseph 49085

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Livonia 48150

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Charlotte 48813

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1050 S. Van Dyke Rd.
Bad Axe 48413

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6248 Hardy Ave. #9
East Lansing 48823

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Freeland 48623

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Flint 48504

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Portage 49081

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Ann Arbor 48104

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Grosse Pte. Park 48236

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Flint 48504

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6060 Duck Lake Rd.
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2841 Monroe
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1500 Sandhill Road
Mason 48854

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Holland 49423

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Detroit 48224

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Northville 48167

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Marquette 49855

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Ann Arbor 48103

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Alma 48801

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Norton Shores 49441

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Gaylord 49735

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Coldwater 49036

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St. Lawrence Hospital
Lansing 48914

Branks DJ Megler, MD
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Grosse Pointe Park 48236

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Wayne 48184

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515 Lakeside Drive, SE
Grand Rapids 49506

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6850 Division Avenue, S.
Grand Rapids 49508

Lars R. Van Putten, MD
169 S. Prospect St.
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Criteria for arbitrators – doctors, lawyers,

(Here are the complete criteria for physician, hospital, attorney and public arbitrators to serve on Michigan's new arbitration panels to settle medical malpractice disputes. The criteria were approved by the Michigan Insurance Commissioner. Application forms for physicians wishing to serve as arbitrators may be obtained from Michael Arford, American Arbitration Association, City National Bank Building, Suite 1035, Detroit, 48226.)

The Michigan Insurance Commissioner has directed the AAA that it must

(1) place on the physician arbitrator lists only physicians who are of the same licensure classification (MD, DO) as the respondent;

(2) that it shall be the policy of the AAA insofar as possible to provide respondents in arbitration actions with medical arbitrators in the respondent's specialty or area of practice with comparable training, experience and current level of professional activity; and

(3) that the AAA make every possible effort to have no person serve as arbitrator more than two times in a single year.

Physician Arbitrator Criteria

The criteria are minimal criteria which must be met for inclusion on the Medical Arbitration Panel. However, the Arbitration Advisory Committee to the Commissioner of Insurance has the authority to decline an applicant on the basis of further investigation and an individual case assessment.

1. Panelist must be a physician licensed and practicing in Michigan, Ohio, Illinois, Indiana or Wisconsin.

2. Panelist must be board certified, board eligible or recognized as a competent consultant or practitioner by his/her peers (county medical/osteopathic society, hospital-medical staff or specialty society) in his/her area of medical practice.

3. Panelist utilizing hospital facilities must show that the hospital is accredited by its respective nationally-recognized accrediting bodies.

4. Panelist must not have had license suspended or revoked in any state, and must not have been convicted of a felony.

5. Panelist must have been in active practice at least five (5) years in his/her field of specialization.

6. Panelist must spend an average of at least twenty-five (25) hours per week in active patient care. Exceptions may be made in the case of physicians whose total professional medical activities indicate a knowledge and expertise of current patient care.

7. Panelist must be approved by the screening process established by the Arbitration Advisory Committee.

Hospital Administrator Criteria

The criteria are minimal criteria which must be met for inclusion on the Medical Arbitration Panel. However, the Arbitration Advisory Committee to the Commissioner of Insurance has the authority to decline an applicant on the basis of further investigation and an individual case assessment.

1. Panelist must be currently actively employed as the administrator of a JCHA or AOA accredited hospital in Michigan, Ohio, Illinois, Indiana or Wisconsin.

2. Panelist must not have been convicted of a felony.

3. Panelist must have at least five (5) years experience as a hospital administrator.

4. Panelist must be approved by the screening process established by the Arbitration Advisory Committee.

ublic and hospital – all here

Attorney Arbitrator Criteria

The criteria are minimal criteria which must be met for inclusion on the Medical Arbitration Panel. However, the Arbitration Advisory Committee to the Commissioner of Insurance has the authority to decline an applicant on the basis of further investigation and an individual case assessment.

1. Panelist must be licensed to practice and in good standing with the State Bar of Michigan, Ohio, Illinois, Indiana or Wisconsin.

2. Panelist must have been in active practice of law for at least five (5) years.

3. Panelist must devote at least twenty-five (25) hours per week to active client representation.

4. Panelist may not have more than 25% of practice in handling or servicing of medical malpractice claims over any immediately prior 2 year period.

5. Panelist must never have been suspended or disbarred from the practice of law in any state, and must not have been convicted of a felony.

6. Panelist must be approved by the screening process established by the Arbitration Advisory Committee.

Public Member Arbitrator Criteria

The criteria are minimal criteria which must be met for inclusion on the Medical Arbitration Panel. However, the Arbitration Advisory Committee to the Commissioner of Insurance has the authority to decline an applicant on the basis of further investigation and an individual case assessment.

1. Panelist must have attained a high school diploma or have a GED equivalent or have equivalent experience.

2. Panelist must have or have had, within the last five years, substantial leadership responsibilities (decision making or problem solving responsibilities) in an organization of which he or she is a member or in which he or she has participated.

3. Panelist must not have been convicted of a felony.

4. Panelist or members of the panelist's immediate family (persons living in the same household as the panelist or a person who is financially dependent upon the panelist) shall not be a health care provider, lawyer, a person associated with a hospital, clinic, HMO or sanitarium or a person associated with the insurance industry.

5. Panelist must be approved by the screening process established by the Arbitration Advisory Committee.

"Discovery Rule Applies to Suit Over Broken Catheter"
Michigan Court of Appeals, Aug. 28, 1975
from *The Citation,* Vol. 32, No. 10

"Suit Against Podiatrist Filed Too Late"
Michigan Court of Appeals, Aug. 13, 1975
from *The Citation,* Vol. 32, No. 10

"Blue Cross HMO Liability"
Michigan Common Pleas Ct, March 20, 1975
from *The Citation,* Vol. 32, No. 10

"Hospital Liable for Lack of Procedure for Proper Selection of Eye Donors" Michigan Court of Appeals, Aug. 11, 1975 from *The Citation,* Vol. 32, No. 12

"Order to Produce Hospital Records Overturned" Michigan Court of Appeals, July 22, 1975 from *The Citation,* Vol. 32, No. 12

"Physician Practicing in Hospital Subject to City Tax" Mich. Sup. Ct., Nov. 25, 1975 from *The Citation,* Vol. 32, No. 11

"Hospital and Osteopath Not Liable for Back Treatment"
Michigan Court of Appeals, October 13, 1975
from *The Citation,* Vol. 33, No. 1

"Uphold Libel Suit for Physician's Report"
Michigan Court of Appeals, November 14, 1975
from *The Citation,* Vol. 33, No. 2

"Jury Should Decide Suit Against Chiropractor"
Michigan Court of Appeals, June 9, 1975
from *The Citation,* Vol. 33, No. 3

MSMS Auxiliary assesses its year

The pluses and minuses of the 1975-76 year, its 50th, are summarized in the MSMS Auxiliary's annual report. The pluses outweigh the minuses.

The Auxiliary exceeded its previous year's fund-raising efforts for the AMA's Education Research Fund, with the Macomb County auxiliary leading with its total of $3,700 raised.

The Auxiliary added 350 new members to its rolls, but declined overall in membership by 69 persons.

The Auxiliary successfully worked with MSMS to defeat HB 4804, the bill which would have required annual examination of every physicians' file before recertification and would have added two more public members to the Medical Practice Board. The Auxiliary also registered another successful Legislative Day when members met with their legislators and learned of medically-related bills.

The Auxiliary concentrated on communications, participated in Immunization Action Month and National High Blood Pressure Month, sent its successful project ideas to a national auxiliary Project Bank, and praised the invitation from the Wayne County Medical Society Council to the WCMS Auxiliary president to join regular meetings.

Medical assistants seek members

MSMS members are urged by the State of Michigan branch of the American Association of Medical Assistants to aid in swelling the ranks of AAMA rolls in Michigan. The appeal to doctors to personally urge their medical assistants to join the AAMA is made in the state organization's annual report, published late this spring.

"Our national goal for membership this year is 20,000 members throughout the US," says the report. "At present, we have 16,000 members." The report also suggests that physicians aid the cause by helping financially with their assistants' membership dues.

The statewide organization has 960 members. Sixty-three of them this year became Certified Medical Assistants, for a Michigan total of 103 CMAs.

The state's medical assistants celebrated the week of April 18, declared "Medical Assistants' Week in Michigan" by Gov. Milliken; held summer, fall and mid-winter seminars and an annual convention. It contributed to the Michigan Health Council and its own Maxine Williams Scholarship Fund and assisted MSMS with the television answer program, "Housecall," over Channel 56, Detroit.

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PROGRAM

Friday, Sept. 17: Registration 12:00-1:00 PM.

1:00PM-5:00PM **JOHN BELLOWS MD:** Welcoming Address; **LEON JACOBSON MD:** Introduction; **LEON RESNEKOV MD:** Overview of CV Disease Today; **HARRY FOZZARD MD:** Cardiac Arrhythmias and Sudden Death; **LEON RESNEKOV MD:** Mgmt. of Cardiogenic Shock; **EARL SILBER MD:** Tmt. of Congestive Heart Failure; ROUNDTABLE DISCUSSION, O&A, TUTORIAL SESSIONS.

6:00PM-8:30PM DINNER — **OGLESBY PAUL MD:** Prevention of CV Disease

Saturday, Sept. 18

8:00AM-12:00: **GARY WILNER, MD:** Cardiorespiratory Resuscitation: **JOSEPH MESSER MD:** Eval. of Patients for Coronary Artery Surgery; **JOEL MORGANROTH MD:** Echocardiography; **KENNETH ROSEN MD:** Eval. of Patient with Cardiac Conduction Disease.

12:30PM-1:45PM: LUNCH — **JOEL MORGANROTH MD:** Computerized Echocardiography.

2:00PM-5:00PM: TUTORIAL SESSIONS, SMALL GROUP CONFERENCES.

Sunday, Sept. 19

8:00AM-1:00PM: **ROGELIO MONCADA MD:** Diagnostic X-Ray in CV Disease; **GEORGE KROLL MD:** Anticoagulants in Myocardial Infarction; **WILLIAM WEHRMACHER MD:** Office Mgmt. of Hypertension; **SUZANNE OPARIL MD:** Hypertension and Sequelae; ROUNDTABLE DISCUSSION, O&A, SMALL-GROUP CONFERENCES. TUTORIAL SESSIONS.

FEE: $200

(Fee includes Dinner with guest lecture on Friday; Continental breakfast on Saturday and Sunday; and Luncheon with guest lecture on Saturday)

Modestly priced guest rooms are available at the Center.

For Information And Registration Write Or Call:

Mr. Richard Muetze, Program Coordinator
Center for Continuing Education
1307 East 60th Street
Chicago, Illinois 60637

Tel. No. 312/753-3185

category 1 programs

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

DATE: July 7, 14, and 21, Preventive Medicine
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan, Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 1 hour of Category I credit

* * *

DATE: July 17-18, AMA-MSMS Regional CME Program
LOCATION: Northern Michigan University Center, Marquette
SPONSOR: AMA and MSMS
FOR: All physicians
COST: $10 per credit hour
CONTACT: Herbert Auer, manager, MSMS Department of CME Programming
APPROVED FOR: 11-12 hours Category I credit

* * *

DATE: Aug. 4, 11, and 18, Significant Aspects of Athletic Injuries
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan, Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 1 hour of Category I credit

* * *

DATE: August 28-31, Current Topics in Medicine
LOCATION: Grand Hotel, Mackinac Island
SPONSOR: U-M Office of Intramural Education
COST: $150/$55 per day
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 11¼ hours of Category I credit

* * *

DATE: Sept. 1, 8 and 15, Infectious Diseases
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan, Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 1 hour of Category I credit

* * *

DATE: Sept. 2-Nov. 11 — Clinical Endocrinology and Infertility Seminars
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, 48236
SPONSOR: Saint John Hospital
FOR: Internal Medicine — OB-GYN — Family Physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 20 Hours of Category I Credit

* * *

DATE: Sept. 6-Nov. 8, Seminars in Perinatology
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, 48236
SPONSOR: Saint John Hospital
FOR: All interested physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 20 Hours of Category I Credit

* * *

DATE: Sept. 7-Nov. 9 — Oncology Today
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, 48236
SPONSOR: Saint John Hospital
FOR: All interested physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 20 Hours of Category I Credit

* * *

DATE: September 10-11, Anesthesiology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $60
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 8½ hours of Category I credit

* * *

DATE: September 15, Otolaryngologic Problems in Family Practice
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: Michigan Academy of Family Physicians
COST: $60
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 7 hours of Category I credit

* * *

DATE: September 17-18, Psychiatry Conference, "Diagnosis and Management of Adult Psychiatric Syndromes"
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $80
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: Sept. 22 — Allergy & Immunology Seminar
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, MI 48236
SPONSOR: Saint John Hospital
FOR: Allergy — Immunology
COST: $50
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 7 Hours of Category I Credit

* * *

DATE: Sept. 29, Infectious Disease Symposium
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 4 hours of Category I credit

* * *

DATE: October 5, Continuing Pathology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: Undetermined
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: October 12-13, Diabetes Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $60
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 13½ hours of Category I credit

* * *

DATE: October 14-16, Family Practice Review
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: Michigan Academy of Family Physicians
COST: $170
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: October 19-21, Cardiology for Internists
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $170
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: October 22-23, Psychiatry Conference, "Common Problems in Child and Adolescent Psychiatry"
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $80
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: November 8-9, Abnormal Hemoglobin and Thalassemia
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: American Society of Medical Technologists
COST: $70
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 15 hours of Category I credit

* * *

DATE: November 23, Continuing Pathology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: Undetermined
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

The following have been accredited by MSMS Commission on Continuing Medical Education as of June 9, 1976.

Organizations:

Michigan State Medical Society
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Grace Hospital, Detroit
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Pontiac General Hospital, Pontiac
Saginaw Cooperative Hospitals, Inc., Saginaw
St. John Hospital, Detroit
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
Wayne County Psychiatric Hospital, Eloise
Ypsilanti State Hospital, Ypsilanti

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

How to use U-M Media Library for Category I CME Credit

By Louise Garman and Robert K. Richards, PhD
U-M Office of Intramural Education

Category I credit is of growing importance to physicians wishing to qualify for the AMA Physician Recognition Award and, in Michigan, for compliance with the new continuing medical education (CME) requirements for relicensure.

Awarding of Category I credit is restricted to CME sponsoring organizations and institutions accredited by the AMA Council on Medical Education or by state CME commissions who have been approved for in-state accreditation. The University of Michigan Medical School has long been accredited by the AMA Council as a CME sponsor; our Towsley Center courses and community visiting programs serve as important sources of Category I credit for physicians in Michigan and neighboring states.

Media Library was developed specifically to aid CME efforts in local hospitals. Since Media Library is sponsored by the University of Michigan Medical School, an accredited organization, it is possible to earn Category I credits for the use of Media Library programs under appropriate conditions.

Media Library use within hospitals accredited by the AMA or the state CME commission can serve as a source of Category I credit if approved by the individual or committee responsible for CME in that hospital. A record of Media Library usage and an evaluation process should be maintained.

Use of Media Library programs within hospitals without CME accreditation can serve as a source of Category I credit providing a local physician assumes responsibility for planning and coordinating the use of Media Library in community CME activities and certain other conditions are met. The responsible local physician should contact Media Library Services to arrange for conditions of use which can allow the awarding of one-half hour of Category I credit for each occasion a Media Library program is used in community CME activities.

Most often when Media Library programs are used by an individual physician for independent study, one-half hour of Category V-A credit is earned for each program studied. For Michigan CME requirements there is a limit of six hours in this classification. However, if after studying a program the individual sends his name and address, the Media Library program title, the name of the subscriber through whom the program was obtained, and the completed post test to Media Library Services, we will award one-half hour of Category I credit for each program studied.

For further information about the use of Media Library programs and CME credit, please contact Louise W. Garman, MA, manager, Media Library Services, at the following address: Department of Postgraduate Medicine and Health Professions Education, Towsley Center for Continuing Medical Education, Ann Arbor, 48109.

Most U.S. doctors favor CME for re-registration

More than two-thirds of physicians surveyed by the AMA say they favor a continuing medical education requirement as a prerequisite to re-registering their licenses.

The poll is reported in the April 26 issue of the Impact section of *American Medical News,* a weekly newspaper for physicians published by the American Medical Association.

"The endorsement by a large proportion of American physicians of the continuing education concept as a criterion for licensing privileges has particular significance in light of the attention focused today upon the issue of physician competence," the AMA said.

Physician opinion on who should assure compliance with the continuing education requirement was divided. State medical associations were preferred by almost 30 per cent. Others suggested medical specialty organizations, state medical examining boards, and the American Medical Association.

Almost three-fourths of the doctors surveyed said they agreed with the suggested national baseline of 150 hours of continuing education every three years, as used by the AMA Physicians Recognition Award.

Still Available

AMA's plaque that reads, "I invite you to discuss frankly with me any questions regarding my services or my fees. The best-medical service is based on a friendly, mutual understanding between doctor and patient." Order OP-33 at a cost of $2.40 each or $2.19 each for 100 or more from AMA's Public Affairs Division, 535 N. Dearborn St., Chicago 60610.

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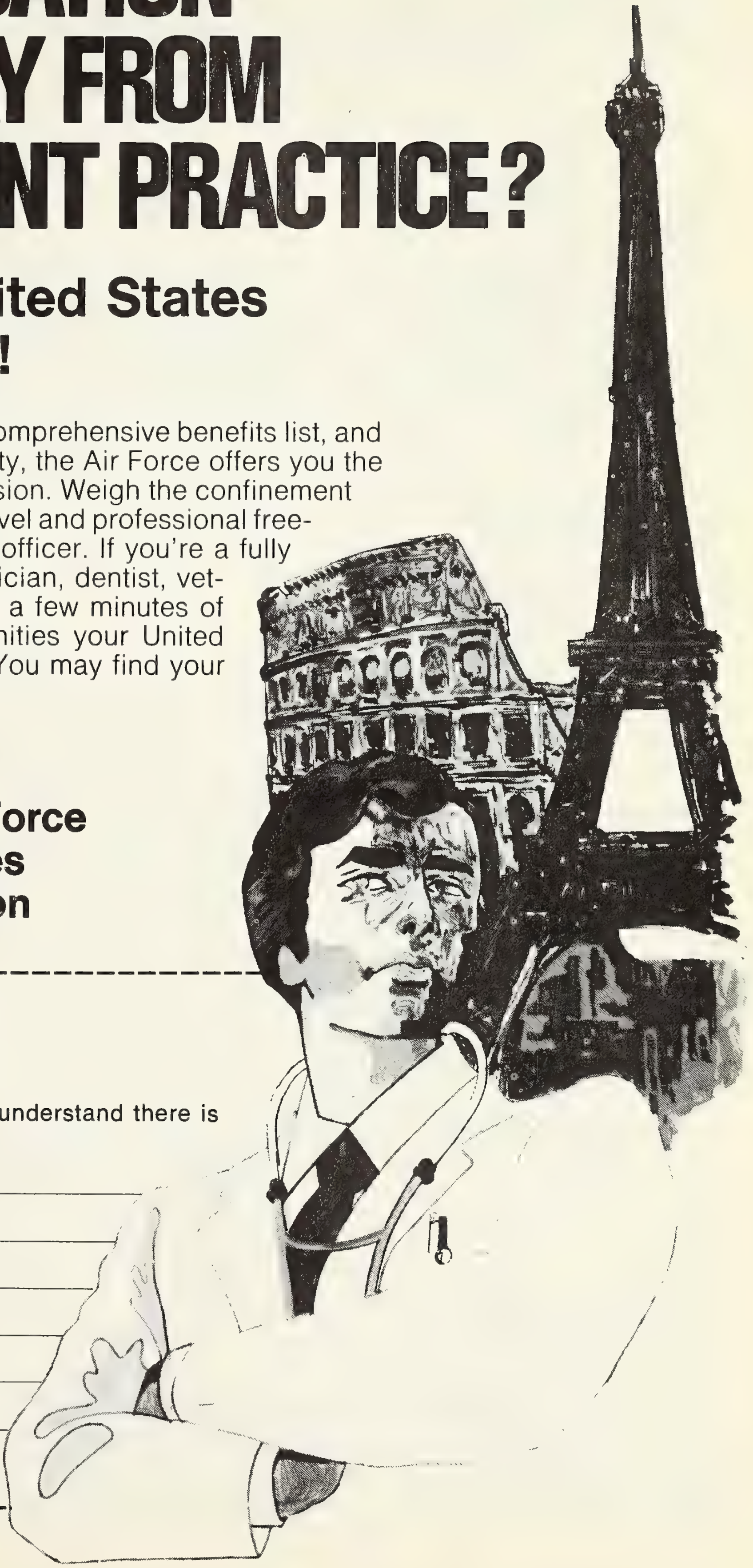

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Air Force Medicine

In Memoriam

Gerald L. Ackermann, MD
Saginaw

Retired Saginaw surgeon Gerald L. Ackermann, MD, died May 12 at the age of 69. Doctor Ackermann was former chief of surgery at St. Mary's Hospital, Saginaw and also was affiliated with St. Luke's and Saginaw General hospitals.

James H. Blain, MD
Grosse Pointe Park

Long-time Detroit-area surgeon James H. Blain, MD, died May 26 at the age of 66. Doctor Blain was a native of Arizona and was graduated from the Wayne State University School of Medicine. He was a member of the American College of Surgeons.

William P. Boles, MD
Flint

Past president of the Flint Academy of Surgery, William P. Boles, MD, died May 9 at the age of 82. Doctor Boles, an otorhinolaryngologist, was a graduate of the University of Toronto Medical School. He practiced in Canada for eight years before moving to Flint. Doctor Boles received the MSMS 50-year award in 1970 and in 1961 was honored for 20 years' service with the Selective Service System.

Edward M. Bradley, MD
Saginaw

Former medical director of the Saginaw Community Hospital TB Unit, Edward M. Bradley, MD, died May 5 at the age of 62. A native of Rumania, he was a graduate of the faculty of medicine, University of Bucharest. He had practiced in New Jersey and Chicago before coming to Saginaw. He was an internist.

Jack Haldeman, MD
Big Rapids

Big Rapids physician since 1954, Jack Haldeman, MD, died May 11 at the age of 53. Doctor Haldeman was former chief of staff at Big Rapids Community Hospital and was county chairman of the Red Cross Blood Bank for several years. He was a graduate of Ohio State Medical School and served on the board of Central Michigan Bank and Trust Co.

Robert L. Hoyt, MD
Grand Rapids

Robert Louis Hoyt, MD, Grand Rapids anesthesiologist since 1958, died May 4 at the age of 51. Doctor Hoyt was a fellow of the American College of Anesthesiologists, a diplomate on the American Board of Anesthesiology, and member of the Michigan Society of Anesthesiologists. He was a graduate of the University of Illinois medical school. He was affiliated with Blodgett Memorial Hospital and had been secretary and treasurer of the Kent County Medical Society.

Grove S. Jaeger, MD
Roseville

Former medical examiner for 20 years with the Federal Aeronautics Administration, Grove S. Jaeger, MD, died May 4 at the age of 70. Doctor Jaeger was a native of Colorado but had practiced in the Detroit area for 50 years. He was a graduate of Wayne State University School of Medicine and also served with the Selective Service System for 30 years.

James Kennary, MD
Grosse Pointe Park

Recipient in 1970 of the MSMS Certificate of Commendation, James M. Kennary, Sr., MD, died May 9 at the age of 71. Doctor Kennary had served over 40 years as family physician to east side Detroiters and was a member of the state and national academies of family physicians. He served several years as an MSMS delegate and was a longtime member of the Wayne County Medical Society Ethics Committee. He was affiliated with Detroit Memorial, St. John, Bon Secours and Jennings Memorial hospitals in the Detroit area. He was a graduate of St. Louis University College of Medicine.

Fred O. Lepley, MD
Detroit

Retired Detroit family physician and obstetrician-gynecologist, Fred O. Lepley, MD, died May 8 at the age of 85. Doctor Lepley had practiced for 52 years. He was a graduate of Western Reserve Medical School and was affiliated with Cottage and Evangelical Deaconess hospitals in the Detroit area. He was a member of the International College of Surgeons and the Detroit Surgical Society.

Edgar Martmer, MD
Coloma

Past president of the American Academy of Pediatrics, Edgar Martmer, MD, Coloma, died May 22 at the age of 75. Doctor Martmer also had served on the MSMS Council and had been active with the Wayne County Medical Society. He was past president of the Detroit Pediatric Society and was former chief of staff at Harper Hospital in Detroit. He had served as an associate professor of pediatrics at Wayne State University School of Medicine. He moved to Coloma in 1969.

Clarke M. McColl, MD
Detroit

Former Ford Hospital Department of Medicine chairman Clarke Munro McColl, MD, died May 19 at the age of 78. Doctor McColl had served as senior consultant at the hospital from 1966 to 1971. He was a graduate of the University of Michigan and a member of the American Society of Internal Medicine. He had served as chairman of the Wayne County Medical Society Ethics Committee and was a diplomate, American Board of Internal Medicine; Fellow, American College of Physicians, and member, American Rheumatism Association.

Yoshikazu Morita, MD
Birmingham

Vice-chief of staff for clinical affairs at William Beaumont Hospital, Royal Oak, Yoshikazu Morita, MD, died May 20 at the age of 55. Doctor Morita was former chief of medicine at both Beaumont and Hutzel hospitals in the Detroit area. He was a graduate of Wayne State University School of Medicine and was professor of medicine at WSU. An internist, he was a member of the American Federation for Clinical Research.

John B. Rieger, MD
Detroit

John B. Rieger, MD, Detroit internist and former head for 25 years of Detroit Edison's department of medicine, died May 3 at the age of 90. A native of Pennsylvania, he had lived in the Detroit area for 55 years. Doctor Rieger was a graduate of the Harvard Medical School and was affiliated with Detroit General Hospital. He was a member of the American College of Physicians.

Maurice Wilde, MD
Arlington Heights, Ill.

Long-time Warren family physician Maurice M. Wilde, MD, died May 10 at the age of 76. Doctor Wilde had resided in Arlington Heights, near Chicago, since his retirement in 1973. He served many years as health officer for Macomb County and was past president of the Macomb County Medical Society. He was a graduate of the Wayne State University Medical School and was affiliated with Holy Cross Hospital, Detroit.

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INTERNISTS, Certified or Board Eligible, for five doctor general internal medicine department in multi-specialty clinic. Sub-specialty practice possible. Fine N.E. Wisconsin City of 100,000. Excellent facilities. Starting salary and fringe benefits over $46,000. Early partnership. Availability — immediate thru July 1977. Reply Box #4, 120 W. Saginaw Street, East Lansing, Michigan 48823.

WANTED: Ophthalmologist, Board Certified or eligible. Busy practice in Cadillac, Michigan. Contact: M. D. Bentley, MD, 502 Cobb Street, Cadillac, Michigan. Office phone (616) 775-9353.

METAL PLAQUE — Honorary certificates, Diplomas, photos, etc. perfectly reproduced in bright silver toned metal with black lettering, all the clarity of the original yet immune to deterioration. Mounted on richly finished walnut base 10 × 12 for only $34.95. Allow three weeks. Perma-Plaque, 778 Rivard, Grosse Pointe, Michigan 48230 (313) 884-9399.

INTERNIST, Primary physician, desires position. Experience in Emergency Medicine, Administration, Industrial Medicine, Institutional Medicine and Civil Service. Will accept position requiring travelling. Reply Box #7, 120 W. Saginaw Street, East Lansing, Michigan 48823.

Family Practitioners wanted in busy 17 man multi-specialty group; Foundation is being built around current four-man Family Practice Department. Pharmacy, Laboratory and X-Ray available at the Medical Center. Guaranteed salary, first year. Liberal fringe benefits. Call or write: Cedarwood Medical Center, P.C., Roger A. Swierbut, Administrator, John M. Proos, M.D. Area Code (616) 983-0571, 820 Lester Avenue, St. Joseph, Michigan 49085.

OPENINGS for career oriented emergency physicians beginning July 1976 in a University affiliated hospital. 32,000 visits per year. Fee for service with paid malpractice. Must have two years postgraduate training and/or equivalent experience. For information send Curriculum Vitae to: Director, Emergency Unit, St. Joseph Mercy Hospital, 326 N. Ingalls St., Ann Arbor, Michigan 48104.

NEEDED: Internist, full-time, for review of Social Security disability applicant files at our Lansing, Oak Park and Traverse City offices. Good salary, good fringe benefits; no malpractice insurance required. Deferred compensation available. Inquiries answered confidentially, an equal opportunity employer. Call collect (517) 373-7789 OR Write: Michigan Department of Education, Vocational Rehabilitation Services, Disability Determination Program, Box 1200, Lansing, Michigan 48904, Attention: David P. Gage, M.D., Chief Medical Consultant.

F.P. or Internist for staff position in chronic disease and rehabilitation hospital of 350 beds. Salary $39,000-plus depending on credentials or experience. Excellent fringe benefits. Apply to Medical Director, Kent Community Hospital, 750 Fuller Ave., N.E., Grand Rapids, Michigan 49503.

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New Professional Building — 5001 West St. Joe, Delta Township, Lansing. Quality space available immediately. Excellent location, 70% owner occupied. Still time to design your own suite. Call Collect (517) 482-5539.

WANTED: Staff Physician with or eligible for Michigan License for 350 bed fully accredited hospital for the care of rehabilitation, tuberculosis, psychiatric and chronic disease patients. 40 hours week. Excellent salary and fringe benefits. Reply: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, Michigan 48605.

WANTED: PRIMARY CARE PHYSICIANS: Ready to start practice? Why not investigate dynamic Racine County, site of Wisconsin's "Belle City of the Lakes"? Located between Milwaukee (½ hour) and Chicago (1 hour) on a peninsula in Lake Michigan. 174,000 community with one of the highest per capita income rates in the USA. Excellent private, public, and parochial schools and colleges; nine golf courses; excellent developed harbor for boating and sailing facilities; many small lakes, ski area, hunting and fishing. Close to Medical College of Wisconsin, Milwaukee, and University-Wisconsin Medical School, Madison; three modern general hospitals (656 beds); long term rehabilitation facilities (over 1,000 beds). For full information write Racine County Planning Council, 818 Sixth Street, Racine, Wisconsin 53403 or call (414) 637-9737 collect.

Radiologist, certified, capable, wishes 4 weeks (only) locum tenens in 1977. Mainly diagnostic or limited therapy. Prefer smaller community but will consider all. Michigan licensed, have malpractice insurance. Non drinker. Please give details and preferences first letter. Reply: Box #9, 120 West Saginaw Street, East Lansing, Michigan 48823.

OB-GYN, UROLOGY, AND ORTHOPEDIC specialties to join an established successful practice with 15-man multi-specialty group. Excellent group benefits; retirement plan; modern clinic facilities; progressive community with excellent educational system including two colleges; area population 75,000; great recreational facilities; must be board eligible or certified; Contact: Business Manager, the Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

CHIEF PATHOLOGIST — An immediate opening exists with the Oakland County Medical Examiner's Service. This responsibility includes the supervision of all technical activities within the service as well as the establishment of operating policies and procedures. Our facility provides the most modern equipment available including the full-time professional services of a Toxicologist.

The required qualifications include a valid license to practice medicine or osteopathy and board eligibility or certification in Anatomic Pathology with a definite interest in Forensic Pathology.

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The salary range of $37,700-$40,700, currently under review, is supplemented by an outstanding fringe benefit package which includes, fully paid Blue Cross, a Dental plan, a life insurance package valued at 150% of one's salary, and the traditionally excellent government holiday, vacation, sick leave, and retirement plans.

For additional information contact: Personnel Department, Oakland County Courthouse, 1200 N. Telegraph, Pontiac, Michigan 48053. Telephone: (313) 858-0535.

FOR LAND CONTRACT SALE with moderate down payment and 8% interest to financing bank, with monthly payment of $300.00, a beautiful medical building in a beautiful lakes area of Southern Michigan, where a doctor has had excellent practice for many years and retired due to poor health. Nearest hospital 3 miles from the office, which is large enough for one Doctor and one Dentist. This is a recreation area with high population in summertime and local population of about 4,000. For information contact: Telephone (517) 592-5165 any time day or evening.

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PHYSICIANS AND SPECIALISTS WANTED: Service area of 29,000 people. 61 bed acute care and JCAH accredited hospital. Area can financially support 4.8 additional physicians (HSA Survey). Central Wisconsin area providing all recreational activity opportunities. Contact: D. Brezicka, Administrator, Berlin Memorial Hospital, 225 Memorial Drive, Berlin, Wi. 54923. Telephone: (414) 361-1313.

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DOCTOR: Are you completing your residency or internship with no definite plans? Our group has openings for General Practitioners and all Specialties. For information, please contact Steve Sell, collect (313) 331-5110 or evenings (313) 563-1136.

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POTPOURRI

By Herbert A. Auer, Executive Editor

Almost 45 years ago, *Michigan Medicine* described malpractice as "a direct threat against the medical profession." A malpractice bill died that year (1932) in committee.

* * *

If the AMA ethic about non-advertising is struck down by government, we can expect to see some of the same ads that physicians ran in the nineteenth century. For example, the Battle Creek Daily Journal in January 1884 carried various ads, including one by "Mrs. Dr. Clark" who declared in her ad: "Chronic diseases and causes usually considered hopeless, a specialty."

* * *

"The fruits of their projects and their successes yet to come are incalculable," said C. Joseph Stetler, president, Pharmaceutical Manufacturers Association Foundation, when the PMAF recently awarded $635,000 in grants to 36 research investigators. During the past decade, PMAF has provided $6.1 million to advance research in pharmacology.

* * *

When someone talks to you about the Bicentennial, try to sneak in a question: "Did you know that the life expectancy during the Revolution was 35 years for men and shorter for women?"

That's right, expectancy for women was then lower because of hazards of childbirth, infections, etc.

* * *

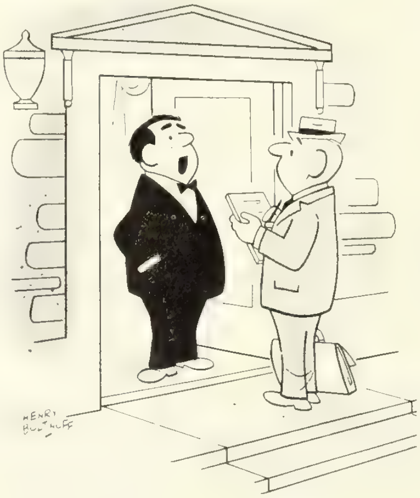
The current issue of *PM Pegboard*, published by Black and Skaggs Associates, tells about a Chicago orthopedic surgeon who now devotes 22 per cent of his total operating expenses and 7 per cent of his gross receipts to his malpractice insurance premiums. "That physician's premiums may rise 276 per cent if Hartford insurance company goes through with its plans to hike rates soon in Illinois — then he will be paying 44 per cent of his overhead costs and 14 per cent of his gross for malpractice insurance."

* * *

Have heard about a doctor who has a sign in his office for the employees to read. It says: "Please remember, the patient is not the enemy."

* * *

The toll of breast cancer is stressed in the media, and rightfully so. A total of 33,100 Americans this year will die from breast cancer, according to the American Cancer Society. But did you know that the estimated toll from cancer of the lung will be 83,000 and cancer of the large intestine will be 38,900? Cancer deaths are expected to total 370,000 this year.



"I'm voting for Brezhnev. This is the Russian Embassy."

In his book, *Doctoring Together*, author-sociologist Eliot Freidson observes that "the easiest patient is the private (solo) patient. If I tell her to bring the child in to my office she always will because there is a difference of four dollars. The group patient, however, treats the doctor like he was a slave. He says, "I paid you in advance, you come here."

* * *

Syndicated columnist Erma Bombeck recently wrote, "How come the first thing I notice in the doctor's office is whether or not his plants are dead?"

* * *

While researching something the other day, happened on *Michigan Medicine* editorial in September 1965, when MSMS President Oliver B. McGillicuddy, MD, said: "We may well be losing our freedom to practice good medicine undeterred by bureaucratic interference. We are not losing it because of the AMA but in spite of the most dedicated battle ever waged by an organization. If you are one of those doctors who at last realizes that the gratitude of your patients is not enough, then it is your obligation to take an active part in organized medicine."

* * *

Food for thought: Charles Reich wrote in *The Greening of America*, "The real deprivation has not been in terms of material goods but in terms of a deadened mind, a loss of feeling, a life that excludes all new experience. This is the true nature of contemporary servitude."

ne·go·ti·ate \ni-ˈgō-shē-ˌāt\ *vb* **-at·ed; -at·ing** [L *negotiatus,* pp. of *negotiari* to carry on business, fr. *negotium* business, fr. *neg-* not + *otium* leisure — more at NEGATE] *vi* **:** to confer with another so as to arrive at the settlement of some matter ~ *vt* **1 a :** to deal with (some matter or affair that requires ability for its successful handling) **:** MANAGE **b :** to arrange for or bring about through conference, discussion, and compromise <~ a treaty> **2 a :** to transfer (as a bill of exchange) to another by delivery or endorsement **b :** to convert into cash or the equivalent value <~ a check> **3 a :** to successfully travel along or over <~ the turn> **b :** COMPLETE, ACCOMPLISH <~ the trip in two hours> — **ne·go·ti·a·tor** \-ˌāt-ər\ *n* — **ne·go·tia·to·ry** \-sh(ē-)ə-ˌtōr-ē, -ˌtȯr-\ *adj*
syn NEGOTIATE, ARRANGE, CONCERT *shared meaning element* **:** to bring about by mutual agreement

MICHIGAN MEDICINE

FFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 8 AUGUST 1976

Michigan physicians have a major new force working in their behalf, the new MSMS Negotiations Division. Ordered by the MSMS House at its annual meeting in May, the new division is already at work. See pages 424-425 for photos and a feature article on the new division.

Does required continuing medical education help, as it is designed to, or does it just make things more complicated? That question is discussed thoroughly on pages 428 and 430 by the immediate past director of the U-M Medical Center Office of Intramural Education.

With the Michigan legislature again in session after its summer recess, the time is right for a review of the status of key medical legislation. See pages 435-436.

Michigan doctors speak out — on what we really need to do to get more rural MDs; on how physicians can help cut costs of medical care; on the need for physicians to identify and treat youthful alcoholism; on personal crisis intervention and the importance of ensuring good dental development in infants and toddlers.

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue

Problems of infection and immunities, seen from all specialties' angles, will be the theme of the 1976 MSMS Scientific Meeting Nov. 9-11, at the Hyatt-Regency Hotel, Dearborn. The September issue of* Michigan Medicine *will spotlight plans for this important annual continuing medical education program. Be sure to read it so that you don't miss out on the opportunity.

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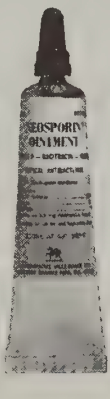

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Physicians must lead in moral and ethical decisions

Robert M. Leitch, MD
MSMS President

There is a most important area which must be addressed by the medical profession in concert with other concerned segments of society. This area embodies the ethical and moral issues which face us.

As advances in medical technology have been developed, situations have arisen which are difficult to solve. Continuing life support systems for hopelessly-ill patients demand immediate study.

How many Karen Quinlans can we support? — Who finally "pulls the plug?" — and when?

How many cases of terminal renal failure can we afford to keep on dialysis? — and which ones?

There are other issues which need attention. The field of recombinant DNA research is somewhat frightening. I am not a scientist, but I am led to believe that the biochemistry involved in this field is simple enough that it may be undertaken by anybody with a smattering of knowledge in this area. What will be the effect of new viruses and possibly other new organisms which develop from this research? Who is to do this work and under what constraints?

The energy question also should concern doctors. With the limited supplies of fossil fuel due to be exhausted by our tricentennial and probably much sooner, what are we doing to develop other forms of energy? Is the threat of nuclear power so great that it must be abandoned in spite of the fact that it seems to be the best alternative source of energy at present?

Because physicians are highly educated and deeply concerned with the physical well being of people, we must be among the leaders who will make the decisions in these moral and ethical areas. The pressures of our day-to-day work or just plain apathy does not provide a valid excuse for our failures to come to grips with these problems.

Doctors have been leaders in this country from its earliest days. Five of the signers of the Declaration of Independence were doctors. Among the thirty-eight framers of the Constitution, two were doctors. There have been doctors in every Congress of the United States including the Continental Congress of 1774. Doctors have served in the executive branch of government. Many have been governors including Doctor Woodbridge Nathan Ferris who served as governor of Michigan from 1913 to 1916. We have five members in the present Congress.

This is the year for us to get the third century of our great country off to a good start. We have a unique opportunity in this respect because future generations will look back to this milestone to see what we accomplished with our stewardship.

We must not be found wanting, but must be remembered as a generation who helped shape the destiny of future generations with imagination, dedication and honest hard work.

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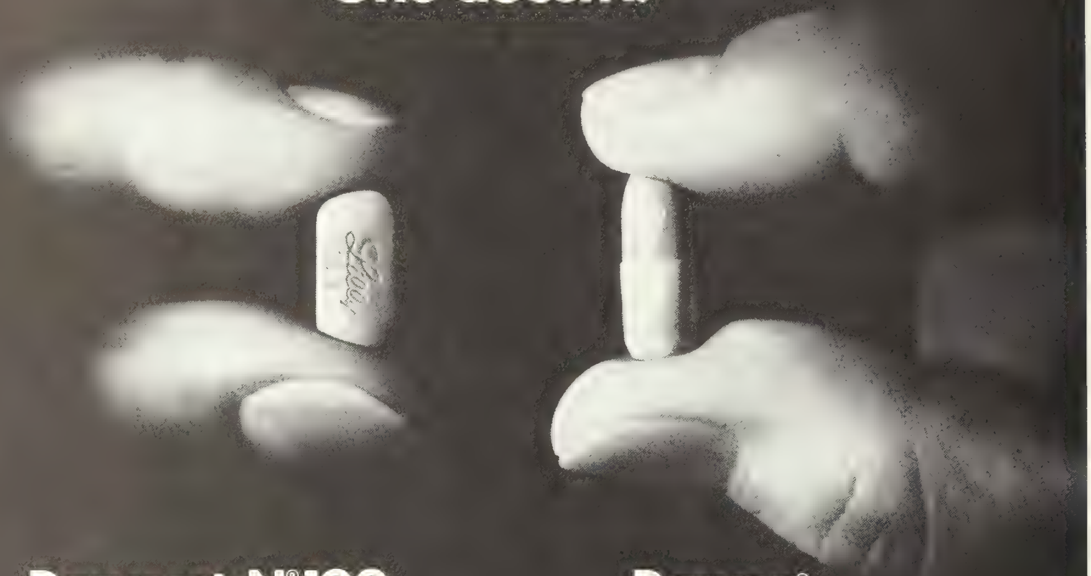

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How you benefit as an MSMS member

— with your eligibility for enrollment under two new group insurance plans for workmen's compensation and office maintenance.

Two new group insurance plans now are available to MSMS members, a workmen's compensation policy and an office package policy covering fire, theft, liability and other conditions.

The new plans bring to six the total of group insurance coverages currently offered to MSMS members. "The group insurance plans have great value in that they provide present and prospective members of MSMS broad insurance protection at low net cost," according to Robert M. Leitch, MD, MSMS president.

Extensive research was undertaken by Stratton-Cheeseman and Associates, Inc., MSMS insurance administrators, to ensure the new programs would offer advantages to MSMS members of initial cost savings, potential dividends, individual policy rating, custom-designed protection, expert risk analysis and counseling, ease of enrollment and prompt, personal claims service.

Both of the plans have a dividend feature, which, in combination with competitive rating, can result in substantial cost savings for the members taking advantage of the program.

Two additional features are noteworthy. First, the group dividend, which is based upon total group experience, may be paid to individual policy-holders even though they have suffered losses during the year. Second, qualified properties owned by members also may be put into the group in addition to the basic office location.

The insurance administrators would like to see a large initial enrollment in the two new plans, as it will greatly benefit the insured members to have a good spread of risks, thereby increasing the potential dividends.

"The new Workmen's Compensation and Office Package policies, together with the existing group life, business overhead expense coverage, disability income protection and accident insurance combine to provide the members outstanding insurance cost reductions at all age levels," says Doctor Leitch.

"I am pleased MSMS has taken the steps necessary to implement these plans, and pledge to the members that MSMS will continue to improve upon and add to the program."

Radiologists, pathologists, ER physicians and anesthesiologists united July 21 at MSMS headquarters to fight proposed changes in their payment procedures by Blue Cross/Blue Shield. The group was drawn together by the renamed MSMS Negotiations Committee, chaired by Donald K. Crandall, MD, Muskegon, center. The committee leads the new MSMS Negotiations Division, staffed by William Madigan, right. At left is Hugh H. Miley, MD, Birmingham anesthesiologist.

The new MSMS Negotiations Division is part of the renamed MSMS Bureau of Economics, John Anthony, manager, left. Assisting the Negotiations Committee are other MSMS committees, including the Committee on Uniform Claim Form and Coding Procedures, John B. Bryan, MD, Royal Oak, center chairman. Representing pathologists at the meeting was Leo W. Walker, MD, Lansing, right.

The new Division, created in May by the MSMS House of Delegates to represent all Michigan doctors in their deliberations, is working first to help those hospital-based doctors affected by the Blues' proposals. Organizing initial efforts at the meeting were, from left, Robert A. Songe, MD, Dearborn radiologist and member of the MSMS Negotiations Committee; Thomas C. Payne, MD, Lansing radiologist; Victor Curatolo, MD, Mt. Clemens, president, Michigan Radiological Society, and Robert Wylin, MD, Detroit pathologist.

New MSMS Negotiations Division gives Michigan doctors strong voice

New MSMS Negotiations effort demands support of all Michigan physicians

By Judith Marr
Managing Editor

The key to the success of the new MSMS Negotiations Division is the support and participation of all Michigan physicians, says Donald K. Crandall, MD, Muskegon, chairman, MSMS Negotiations Committee.

"If doctors back us and we have their support, we can speak for them," says Doctor Crandall, whose committee is spearheading the MSMS negotiations efforts. "We can act as a unified force."

It was to give Michigan doctors more unity and strength that the MSMS House of Delegates at its 1976 Annual Session in May resolved that the new division should be formed. The original language of Resolution 76A-63 called for MSMS "to approve and develop the expertise requisite to proper bargaining and negotiating of working agreements for MSMS rank and file at the state and county levels."

The creation of the MSMS Division follows closely the development of the new AMA Negotiations Department. The MSMS Division leaders and staff already have met with AMA negotiations personnel and won their guarantee of support and aid when needed.

The new MSMS Negotiation's Division's first activities have been to offer aid to Michigan pathologists and radiologists in their attempts to thwart Michigan Blue Cross-Blue Shield efforts to change payment procedures for those hospital-based physicians.

The new division also is moving to collect non-participation proxies in the Blues programs from all MSMS members.

"The more votes we obtain the more clout we will have," emphasizes Doctor Crandall of this crucial step. The House directed the division to "immediately collect non-par proxies from all physicians, to be held in escrow at MSMS, to be executed in the event of failure at negotiations."

Letters are to go in the mail this month to all MSMS members to ask for their votes.

The Negotiations Division's activities will serve all Michigan doctors beleaguered by and in contention with powerful forces, and this advocacy will extend to dealings with government, hospitals, other physicians, public and private agencies. The new service will focus many of the activities of MSMS on behalf of its members.

"We have the potential of being pretty busy," says Doctor Crandall.

"It is my hope that the Negotiations Committee and Division will be able to identify problems prior to their becoming crises; to investigate, research and evaluate them and provide some alternatives so that we can act in early stages of the problems," he continues.

Other major goals of the Negotiations Division will be to monitor all conflicts involving physicians around the country, to help anticipate Michigan physicians' problems and provide information on how such problems are handled elsewhere, he says.

How busy and crucial the new negotiations service proves to be to Michigan physicians depends on how effective it is, Doctor Crandall says. And that depends on how the state's physicians respond, he says.

Specifically, the MSMS House empowered the Division to

(1) Identify specific problems amenable to negotiation.

(2) Assemble pertinent data and research problems.

(3) Establish guidelines.

(4) Negotiate solutions.

(5) Devise specific action plans.

(6) Coordinate all negotiation activities of MSMS.

(7) Give assistance to physicians, medical groups and communities as requested for negotiating problems.

(8) Educate the membership regarding the use and techniques of negotiation.

(9) At the earliest time possible, obtain authorization from all MSMS members for the Department of Negotiations of MSMS to be the exclusive bargaining agent for all.

(10) Collect immediately "non-participation proxies" from all physicians, to be held in escrow at MSMS, to be executed in the event of failure at negotiation.

(11) Formulate a "negotiated participation agreement" with third party payors which shall eliminate reasons for non-participation.

At its Midsummer Meeting in July, the MSMS Council added the following duties for the Division:

(1) Identify research areas.

(2) Monitor data collected.

(3) Monitor all disputes.

(4) Provide liaison with groups in contention.

(5) Consider staff support for above.

(6) Recommend to The Council when and where a professional arbitrator should be retained.

(7) Recommend to The Council the appropriate time for pulling proxies.

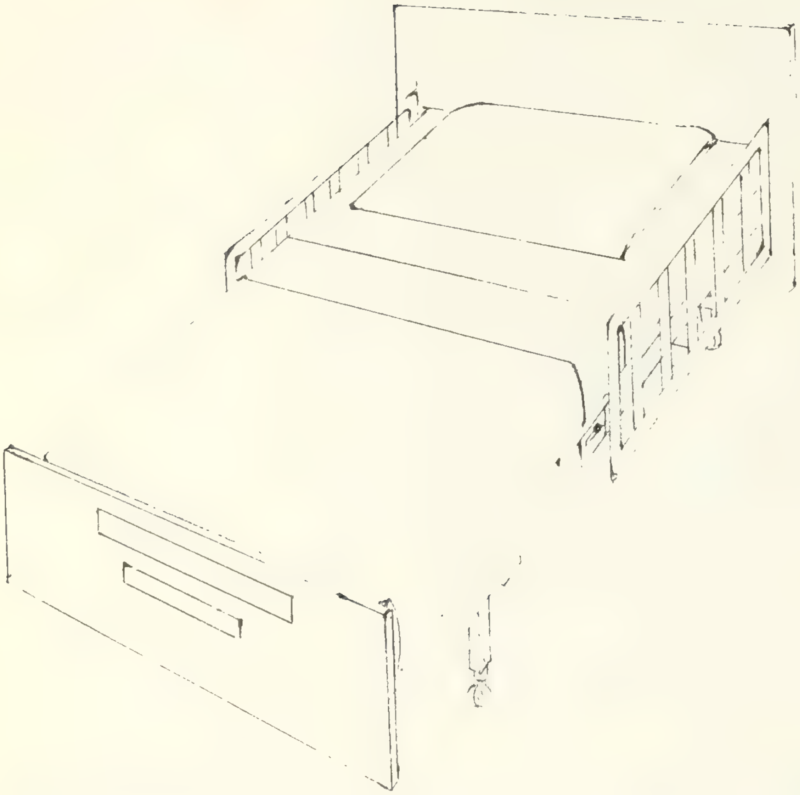
(8) Serve as a link with Medicaid Liaison Committee; monitor use of claim forms, third party carriers.

Committees coordinating efforts with the Negotiations Division include The Medicaid Liaison Committee, chaired by David Siegel, MD, Lansing; Committee on Uniform Claim Form and Coding Procedures, chaired by John Bryan, MD, Royal Oak, and Committee on Third Party Carriers, chaired by Henry Kallet, MD, Jackson. Doctors Siegel, Bryan and Kallet, and Robert Songe, MD, Detroit, comprise the Negotiating Committee.

The Division is staffed by William Madigan. It is part of the MSMS Bureau of Economics, John Anthony, manager.

"The MSMS House granted the new division a wide range of responsibilities. It is to this exciting new challenge that the division staff and committees have dedicated themselves," wrote Doctor Crandall in a recent *Medigram* editorial.

"The result should be greater strength, representation and unity for Michigan physicians."



New regulations set for surplus OB beds

By Don R. Krohn, MD
Southfield

During the past several years hospital administrators have become increasingly concerned regarding the problem of surplus obstetrical beds. In the face of declining birth and obstetrical bed occupancy rates, this problem has grown more acute.

Many observers have concluded that surplus obstetrical beds are not being properly utilized under the current regulations of the Michigan Department of Public Health.

Doctor Krohn is a member of the Task Force on Obstetrical Services and is chairman, Department of Obstetrics and Gynecology, Providence Hospital, Southfield.

Therefore, in June of 1975 the Michigan Hospital Association appointed a Task Force on Obstetrical Services charging the group with the responsibility of developing criteria for the proper utilization of surplus obstetrical beds. Chairman is Robert E. Miller, administrator, Lansing General Hospital, Lansing.

The Task Force, with the cooperation of the Michigan Department of Public Health, surveyed all Michigan hospitals with two or more surplus obstetrical beds and received a response from 64 hospitals. From analysis of the data the Task Force developed the following criteria for using surplus obstetrical beds for clean gynecologic patients.

(A) The hospital should have a minimum of 85% medical-surgical occupancy.

(B) There generally should be a minimum of 500 deliveries per year.

(C) The average length of stay (all patients) should not exceed nine days except that a hospital with higher average length of stay should be given an opportunity to justify its experience prior to denial of its request on this basis.

(D) There should be a minimum of three surplus obstetrical beds.

(E) There should be an absence of major physical plant or operational deficiencies.

(F) Medical and administrative control should be adequate.

(G) The potential for consolidation of obstetrical services in the community should be absent or impractical.

Subsequently, these criteria have been endorsed by both the Michigan Hospital Association and the Committee on Maternal and Perinatal Health of the Michigan State Medical Society.

Based on these recommendations the Department of Public Health has proceeded with promulgation of rules which will implement the criteria developed by the Task Force. As I interpret them, major changes in the new rules are:

(1) Reduction of the required number of surplus beds from six to three.

(2) A new requirement for a minimum 85% average occupancy of medical and surgical beds.

(3) A new but somewhat flexible requirement that the average length of stay not exceed 9.0 days.

Following the Public Hearing of July 7, 1976, the rules will go through bureaucratic channels, i.e. the Legislative Service Bureau, the Department of Attorney General and the Joint Legislative Rules Committee prior to filing with the Secretary of State and final promulgation. It is presently anticipated that these rules will be effective before the end of the year.

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Mandatory CME – springboard or

By Robert K. Richards, PhD
Ann Arbor

The recent law requiring documentation of continuing medical education (CME) participation for licensure renewal has evoked strong reactions among many Michigan physicians. Even those whose personal CME efforts have long exceeded 50 hours per year are anxious about the seemingly arbitrary imposition of a "brownie point" requirement.

Is this law merely another bureaucratic obstacle for the busy physician or does it represent significant progress in upgrading standards for the profession?

To explore this important question let us examine several general trends which have influenced the provisions of the Michigan relicensure law as well as the pros and cons of requiring CME participation for licensure renewal.

Three recent major trends in American society influential in shaping the recent Michigan law are:

1. Efforts to assure the ongoing competence of licensed professionals through relicensure requirements.
2. A movement away from recurrent points of "completing" one's professional education toward a lifelong educational process.
3. Concern about the malpractice insurance crisis.

Doctor Richards was director, Office of Intramural Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School. In mid-August he takes the new position of head of CME programs for the American College of Cardiology.

The Trend Towards Medical Relicensure

Medical relicensure, a joint effort of the profession and state government, has customarily required completion of a specified amount of preparatory education and training in accredited institutions and attainment of a satisfactory score on a written licensure examination. Licensure statutes and processes have been focused on initial entrance into practice and, once successfully completed, have been unlimited in time or scope.

The trend toward periodic relicensure in medicine has been spurred by a general awareness of the vast growth in medical knowledge and technology during the past 25 years and by the growing wave of consumerism. The "knowledge explosion" has led to concerns by the medical profession, government, and the public about its implications for physician obsolescence and continued competence.

The 1967 Report of the National Advisory Commission on Health Manpower signaled a marked change in attitudes when it recommended that professional societies and state governments explore periodic relicensure of physicians based on certification of acceptable performance in continuing education programs or challenge examinations in the physicians' specialty.[1] At the time, most states required only an application form and a modest fee to renew one's license to practice medicine.

In 1971, landmark legislation was passed in New Mexico authorizing the medical practice board to require physicians to document completion of 120 credit hours of CME every three years for renewal of their license to practice. Similar laws have since been adopted in Kansas, Kentucky and Maryland and, within the past year, in Michigan, Ohio, Wisconsin, Utah, California, Arizona, Washington and Illinois. Currently, New Mexico is the only state to have completed a relicensure cycle. The vast majority of that state's 1,200 physicians complied with the CME requirements, although, a few physicians retired or left the state.

These requirements for medical relicensure are part of a national trend toward time-limited licensure. The trend will undoubtedly lead to the adoption of standards for licensure renewal in most professions.

The methods currently considered for relicensure are extensions of the methods used in initial licensure: 1) requiring continued participation in education, usually stressing activities sponsored by accredited organizations and institutions or 2) mandatory periodic re-examination.

stumbling block?

The Trend Toward Lifelong Education

Despite professional ideals of lifelong learning, it has been possible for physicians to "complete" their education after acquisition of their formal credentialing (i.e. licensure, residency completion, and/or specialty board certification). After entering medical practice, participation in CME was voluntary.

During the past 10 years there has been a significant increase in the importance ascribed to participation in CME. Prior to 1968 all CME participation was voluntary with the exception of the longstanding requirement for membership in the American Academy of Family Physicians. Since 1968, CME has been adopted as a membership requirement by 12 state medical societies, several specialty societies and as part of the recertification requirements of the American Board of Family Practice.

The trend leading to adoption of these requirements is based on a presumed, *but not yet demonstrated,* relationship between participation in traditional CME activities and the quality of medical practice. There is also a general belief that professionals never "complete" their education and that continued participation in educational processes is of value per se.

Concern About the Malpractice Insurance Crisis

During the mid-1970's there has been a great concern on the part of the medical profession, state government and the public with the soaring costs of malpractice insurance and difficulties in obtaining coverage. Most current efforts to resolve this crisis are aimed at assuring the availability of insurance and are only beginning to address problems in medical quality assurance which some believe to be partially underlying the insurance crisis.

Dr. Carleton Chapman noted that, "Even though medical malpractice . . . is a legal morass and a medical nightmare, it has great significance where continuing education, relicensure and recertification are concerned. The reason is that . . . the basis of complaint is increasingly . . . failure to possess or exercise due skills. Due skill, as a result of recent legal decisions, is determined by comparing a physician's professional performance with members of his or her own specialty group, regardless of geographic locale. As a result, the physician who cannot show evidence of participation in CME, to stay abreast of advances in his or her profession, is in much greater legal jeopardy than in years past."[2]

The growth of medical malpractice suits has been attributed, in part, to the rise in public expectations of physician performance; diminution of professional-patient relationships in our mobile society; the increase in specialization; the advent of an era of accountability; and an increased willingness to file suit, particularly against individuals with upper socio-economic status. Despite these contributing factors, the major cause of suits, as indicated by the HEW Commission on Medical Malpractice, is unsatisfactory results of medical care.[3]

Although malpractice suits seem better correlated with urban locations and high risk specialties than with demonstrated gaps in overall physician competence or educational deficits, there is a belief that required participation in CME could be an effective therapy in remedying the ill-diagnosed malpractice problem. This belief contributed to the inclusion of the CME for relicensure law in the 1975 Michigan malpractice legislation and is reflected in this legislative staff analysis of the original House Bill:

> By requiring physicians to take a certain number of hours of instruction each year in their field, the general level of competency would undoubtedly be raised. This would surely result in fewer patient injuries and thus lower malpractice premiums.[4]

Mandatory CME – Obstacle or Progress?

Requiring 50 hours of CME for medical relicensure in Michigan is expensive for physicians, patients and CME-sponsoring institutions. These expenses must be justified in terms of accomplishment of the laws' goals: 1) increasing the quality of physician performance or 2) decreasing the incidence of malpractice and its costs. Can required participation in CME be justified as an effective means to achieve these goals?

Studies to date have not documented the effectiveness of traditional CME in accomplishing these goals.[5,6,7] Currently, there are no studies underway nor funding sources encouraging the exploration of these important questions.

> demonstrate that the licensee continues to meet the educational and practice standards for the profession.[9]

If medical relicensure is to provide assurance that practitioners meet appropriate performance standards then only methods which assess what physicians actually do in their practices can accomplish this objective. Mandatory participation in CME or demonstration of current knowledge and skills may be useful components of a competency-based approach but they will not, by themselves, provide this assurance.

Relicensure based on actual physician performance must: 1) provide the public with protection from incompetent practitioners, 2) be generally acceptable to the organized profession, 3) assure realistic standards and due process for the individual practitioner, and 4) be accomplished within the resources which government and the profession are willing to assign to this function.

Mandatory participation in CME will neither assure quality medical practice nor reduce the cost of malpractice. It is, however, an appropriate transitional step toward a more effective approach and clearly establishes some requirement for medical relicensure as "a fact of life." Moreover, it is possible to accomplish given current limitations in methodologies, resources and available time.

To move beyond this initial step toward relicensure related to actual physician performance will require a cooperative effort by state government, the organized profession and medical education. Developmental funding will be required to define appropriate performance levels and develop workable methods to assess physician performance. As promising elements of a performance-based relicensure process are developed, they should be introduced on a trial basis and carefully evaluated.

Hopefully, at some point in the future, laws such as the 1975 Michigan CME for relicensure statute will be an anachronistic monument to an era when *all* physicians did not participate in processes of quality assessment and professional growth as a routine part of their practice habits.

(References available from the author.)

During the past 10 years there has been a growing recognition that the primary purpose of CME is to improve the quality of physician performance. Many leaders in CME believe that this purpose could best be accomplished by linking CME to hospital-based processes to measure the quality of physician performance against agreed-to criteria and, thus, diagnosing performance deficiencies. These deficiencies could then be approached through a variety of interventions, including local CME activities, and the outcomes of these interventions measured by improvements in physician performance.[8]

Learning and improvements in physician performance can, undoubtedly, result from participation in traditional CME courses and meetings and periodic examinations of medical knowledge. However, linking CME to hospital-based efforts seems more likely to have an immediate effect on the care of patients, since it focuses on conditions in the physicians' particular practice situation.

One measurable result already achieved by the Michigan relicensure law has been a formalization and significant expansion of local CME programs which incorporate diagnosed performance deficiencies as one form of needs assessment. The MSMS Commission on CME has provided outstanding leadership to this promising statewide development by establishing standards and an accrediting process for local CME organizations.

It is important to recognize that *CME is an educational process whose potentialities are limited to helping physician-learners achieve their knowledge and skill-related learning goals. Required participation in CME, while it may favorably influence the quality of physician performance, cannot, by itself, assure those outcomes. Participation in CME is not an end itself, it is only a means to an end.*

There are few advocates of relicensure by mandatory periodic reexamination. This proposed method is unlikely to improve the quality of physician performance. Physicians have experienced written examinations as career hurdles in medical school and for licensure and specialty certification. For some practitioners self-assessment or voluntary recertification examinations have served as a helpful, non-punitive way of assessing their learning needs. Most physicians, however, are relectant to trust their careers to required periodic re-examinations developed by "experts" who often lack an understanding of the circumstances under which they as individual physicians are practicing. Despite the acceptance of testing methods for initial licensure, the experienced practitioners' resistance to this approach, the developing "state of the art" in testing practicing physicians and the lack of demonstrated correlation between test results and physician performance should relegate periodic re-examination to voluntary processes within the profession such as self-assessment and recertification, not a method for relicensure.

The recent relicensure proposal presented by the Michigan Public Health Statutes Revision Project (PHSRP) would permit the Medical Practice Board to accept documentation of either or both of the following:

1. Attendance at approved CME courses or programs.
2. Other evidence of continuing competence which the Board determines is necessary to

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the five week period ending July 2, 1976

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1976 This 5-Week Period	1975 Same 5-Week Period	1976 Total To Above Date	1975 Total Same Date	Total Cases for 1975
Rubella	205	234	1,270	1,358	1,975
Cong. Rubella Syndrome	0	0	0	1	1
Measles	1,137	665	5,406	2,912	3,253
Whooping Cough	9	3	41	43	98
Diphtheria	0	0	0	1	1
Mumps	556	1,139	4,723	7,770	9,979
Scarlet Fever & Strep Sore Throat	2,312	1,696	14,628	14,310	23,777
Tetanus	0	0	0	0	0
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	246	229	1,254	1,433	2,877
Salmonellosis (other than S. typhi)	85	63	409	398	864
Typhoid Fever (S. typhi)	2	1	6	2	10
Shigellosis	50	49	297	377	745
Aseptic Meningitis	8	11	49	47	280
Encephalitis	4	14	37	39	168
Meningococcic Meningitis	8	6	43	55	76
H. Influenza Meningitis	22	18	75	68	142
Tuberculosis	145	126	679	592	1,220
Syphilis	78	141	555	822	1,614
Gonorrhea	3,285	2,858	16,152	15,020*	32,472

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

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*correction

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65-02

Courts severely restrict Lansing chiropractors

Report from the MSMS Government Relations staff

Three cases filed by Michigan Attorney General Frank Kelley against chiropractors practicing in Lansing have resulted in severe limitations of those chiropractors' scopes of practice.

Specifically, Judges James T. Kallman and Thomas L. Brown interpreted literally the scope of practice of licensed chiropractors in comparison with scope of practice of licensed medical and osteopathic physicians, all from the licensure statutes of the State of Michigan.

Said Judge Kallman in the case of the Attorney General v. David J. Fachting, DC:

"(Conclusion) Administering an endocardiograph, blood tests, performing acupuncture (or acupressure), performing diathermy, and administering drugs are beyond the scope of chiropractic in that they do not constitute the adjustment by hand of misaligned or displaced vertebrae or procedures preparatory thereto. Holding oneself out as able to perform services capable of being performed by physicians is beyond the scope of chiropractic and is the improper practice of medicine.

"The Attorney General's request for a preliminary injunction is granted."

Judge Kallman expanded and reiterated in the case of the Attorney General v. Frank W. DuChaine, DC:

"The chiropractor's diagnosis is limited to the locating of misaligned or displaced vertebrae of the human spine. It does not include the x-raying of an ankle and making a diagnosis based thereon. Such action by the Defendant was clearly beyond the scope of chiropractic.

"There is a question of whether some of the acts of the Defendant or his holding himself out as having the ability to perform certain acts are "preparatory" to treatment. The statutory definition allows the chiropractor to use x-ray and other approved analytical instruments solely for the purpose of locating the misaligned or displaced vertebrae and other procedures preparatory thereto. Further treatment by a chiropractor is to be the adjustment by hand of misaligned or displaced vertebrae and surrounding bones or tissue. This Court is of the opinion that procedures preparatory thereto includes manipulation by hand. Acupuncture is not within the scope of the statute either as a treatment or a procedure preparatory thereto. Staples for weight loss do not involve the location of misaligned or displaced vertebrae and is clearly not within the scope of the statutes.

"The definition of the practice of medicine prevents one from holding himself out as able to do certain enumerated acts. By listing services available beyond the locating and adjustment by hand of misaligned or displaced vertebrae the Defendant held himself out as able to do certain acts available only to a medical practitioner. This was improper. It was also improper to indicate that intensive care was available in the office. It was improper to advertise the availability of acupuncture and staples for weight loss.

"(Conclusion) Acupuncture, diathermy, staples for weight loss, and diagnosis of an ankle x-ray are beyond the scope of chiropractic and involve the practice of medicine. Holding oneself out as able to perform services available only to medical practitioners is beyond the scope of chiropractic and is an improper practice of medicine."

Judge Brown ruled in the case of the Attorney General and the Michigan Chiropractic Council v. Gerald J. Hall, DC, and Jonas Raguckas, DC, and Marie Raguckas, DC:

"IT IS HEREBY ORDERED that defendants, and each of them and their agents, servants, and employees, and those in active concert or participation with them, unless such other persons are licensed pursuant to the medical practice act, MCLA 338.1801 et seq; *MSA 14.542 (1), or the osteopathic act, MCLA 338.101a* et seq; *MSA 14.571(1)* et seq, *are hereby enjoined and restrained from:*

"1. Prescribing, administering or dispensing drugs as the term "drugs" is defined in sections 1(d) (1) and 1(m) of the Pharmacy Act, 1962 PA 151, as amended; MCLA 338.1101 et seq; *MSA 14.757 (1)* et seq.

"2. Performing or offering to perform acupuncture, drawing blood samples or otherwise inserting any needle or other device into the skin of patients.

"3. Performing any diagnostic test on patients, including "pap and breast" tests and blood pressure tests, except such tests as are expressly and specifically set forth in the chiropractic act, MCLA 338.156; MSA 14.596.

"4. Treating or attempting to prevent, cure or relieve a human disease, ailment, defect, complaint or other condition in any manner other than the adjustment by hand of misaligned or displaced vertebrae of the human spine and surrounding bones or tissues.

"5. Advertising in any manner that defendants can perform any healing art services which defendants are prohibited from performing by order of this Court and the laws of this state."

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[1] Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976.
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Side Effects: No serious complications have been reported from the use of Ergomar (ergotamine tartrate) in the absence of contraindications and in recommended dosages. Unpleasant side effects which may occur include nausea and vomiting, weakness in the legs, muscle pains in the extremities, numbness and tingling of fingers and toes, precordial distress and pain, and transient tachycardia or bradycardia. Localized edema and itching may occur in the rare sensitive patient. Side effects are usually not such as to necessitate interruption of therapy.

Administration and Dosage: All efforts should be made to initiate therapy as soon as possible after the first symptoms of the attack are noted, since success is proportional to rapidity of treatment, and lower dosages will be effective. At the first sign of an attack, or to relieve the symptoms of the full-blown attack, one tablet is placed under the tongue. Another tablet should be taken at half-hourly intervals thereafter, if necessary, but dosage must not exceed three tablets in any 24-hour period. Limit dosage to not more than 10 mg. in any one week.

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Medicaid restorations among legislative actions

By Bruce W. Ambrose, Manager
MSMS Department of Government Relations

Just before its adjournment July 3, the Michigan Legislature established 1977 fiscal year appropriations which will return physicians' Medicaid payments to screens effective prior to the 11% discount ordered effective last Jan. 1 by the Governor.

The Medicaid restorations will take effect Oct. 1, the start of the new fiscal year. The Legislature approved "fifth quarter" appropriations which will extend the current fiscal year to that date.

Other appropriations measures maintain current medical school enrollments in Michigan, shift some public health laboratory services costs to the private sector, and in general maintain current programs in the Departments of Mental Health, Public Health, and Licensing and Regulations.

The Legislature also enacted, in its final days, revised amendments to the Medical Practice Act and statutory immunity to health professionals who provide service to the swine flu mass immunization program.

When legislators return in September, the major health legislation probably will center on the proposed new public health code (PHSRP). Physician Assistant regulatory legislation also is due for activity. Emergency medical services bills are on the calendar for floor consideration in the House, though the required $228,000 to implement regionalized emergency services has not been appropriated for 1976-7.

Actions in 1976 that will affect physicians' practices are:

Appropriations

Department of Social Services: Total budget of $2.2 billion is $172 million over levels of current spending. Total Medicaid budget within DSS appropriations is $810.8 million, shared approximately equally by state and federal allocations. The physician fee line item of $128.7 million is an increase of $32.7 million over current spending, and will provide for usual payments for services as of October 1.

Conversely, the legislation orders several cost containment measures. Physician fee screens will remain frozen at 1974 levels. If it appears that expenditures for the medical assistance program will exceed appropriations, the director of DSS must recommend "additional cost containment measures, including but not limited to reducing the level of payments to health care providers on a pro rata basis . . . " The bill also directs that hospital allowable costs shall be determined on the basis of current economic indices as permitted by the U.S. Department of Health, Education and Welfare, and that basic inpatient care shall be limited by "length-of-stay by diagnosis which does not exceed the 75th percentile of Michigan length-of-stay guidelines" as specified by DSS.

Growth of the Medicaid program is depicted in the following chart.

	1975 Actual Expenditures	1976 Anticipated	1977 Appropriated
Hospital Services	$209.6 Million	$213. Million	$280. Million
Physician Services	99.4 Million	96. Million	128.7 Million
Nursing Homes	154.6 Million	155.4 Million	172.2 Million
Pharmaceuticals	49.7 Million	46.1 Million	67.9 Million
Total Including All Line Items	$615.9 Million	$636.6 Million	$810.8 Million

Medical Education: Appropriations to higher education call for funding of current medical school enrollments. That means a composite student enrollment in Michigan medical schools of 2,867 beginning in September, including 698 first-year students. Authorized medical school enrollments are:

	Total Enrollment	Freshmen Class
Wayne State University	1,024	256
University of Michigan	1,130	238 (includes 50 in INTEFLEX)
Michigan State University		
Human Medicine	424	105
Osteopathic Medicine	289	99

Department of Mental Health: General fund appropriation of $292 million is up more than $30 million from current spending. Staffing patterns in both mental illness and retardation institutions will increase by more than 400 each, based on direct care staffing needs. Three innovations are programmed in the budget: A $400,000 prevention program, 19 psychiatric residencies divided among child psychiatry, forensic psychiatry and community psychiatry, and a depression clinic demonstration project in Ann Arbor.

Department of Public Health: General Fund appropriation is set at $46.6 million, up five million from current spending. The department is ordered to charge fees to providers for laboratory services which previously have been a public service. Several proposed projects, including public health funding of the State House Officers Training Program (SHOTS), were axed in the final days. The family practice residency program was reduced to $500,00 from proposed funding at more than $900,000.

Department of Licensing and Regulations: The Department will get a boost of $700,000 from $4.9 million to $5.6 million. Half the increase is to hire 15 persons to plan reorganization of the department. Two additional personnel are anticipated for the medical science unit, which provides services to the medical, osteopathic and podiatric practice boards.

Regulatory Legislation

House Bill 6433, which is a rewrite of HB4804, was passed. The new bill excises those parts of the original bill which were objected to by the Governor and by MSMS. It now calls for scrutiny of a physician file only when complaints are registered against the physician. Annual review of every physician file, and seven-member sub-boards to hold disciplinary hearings, were stricken. Now two members of the board and a hearings officer will conduct hearings and recommend action to the full board, which must take final action. The bill still provides for two additional public members of the board.

House Bill 6410, which provides immunity to health professionals, both private practitioners and public health personnel, in any mass immunization program ordered by the director of the department of public health. Thus, physicians who participate in the swine flu mass immunization program will be protected from professional liability suits.

Public Act 96, 1976, amends the physical therapists' registration act to require specific training and experience. Physician supervision of physical therapists' activity, and treatment as prescribed by physicians, is required under the new law.

Public Act 14, 1976, requires hospitals to establish smoking and non-smoking patient rooms and other designated areas.

Public Act 103, 1976, establishes the same requirements for nursing homes.

Public Act 53, 1976, requires restaurants seating 50 or more patrons to offer smoking and non-smoking areas.

Proposed Legislation That Has Not Passed:

Much legislation was introduced with varying degrees of success short of actual passage.

Three emergency medical services bills, supported by MSMS and the MESH Council, passed the Senate and are on the House floor ready for action in the fall session. However, the Public Health appropriation bills do not appropriate the required $228,000 funding even if they do pass.

Four variations on chiropractic licensure were introduced. None received committee approval.

Physician assistant legislation supported by both MSMS and the Medical Practice Board has not received initial House approval. Action is expected in the fall.

An MSMS-opposed generic drug bill has passed both houses, but is tied up in conference over a proposed amendment supported by MSMS requiring knowledge of the purchaser when a substitution occurs. The Senate Conference Committee has not yet been appointed.

The proposed Public Health Code (PHSRP) still has to get started in the formal legislative process, though informal activity portends a serious attempt to pass the legislation in the fall.

MM editor named member of SMJAB board

Herbert A. Auer, executive director of *Michigan Medicine,* and manager of the MSMS Department of Communications and CME Programming, is a new member of the board of directors of the State Medical Journal Advertising Bureau. He was elected to the seven-member board at its recent annual meeting. SMJAB is a business organization that solicits advertising for all state medical journals from pharmaceutical firms and other advertisers.

Michigan has not had a board member for 20 years. The most recent was Wilfred Haughey, MD, Battle Creek, former scientific editor for many years.

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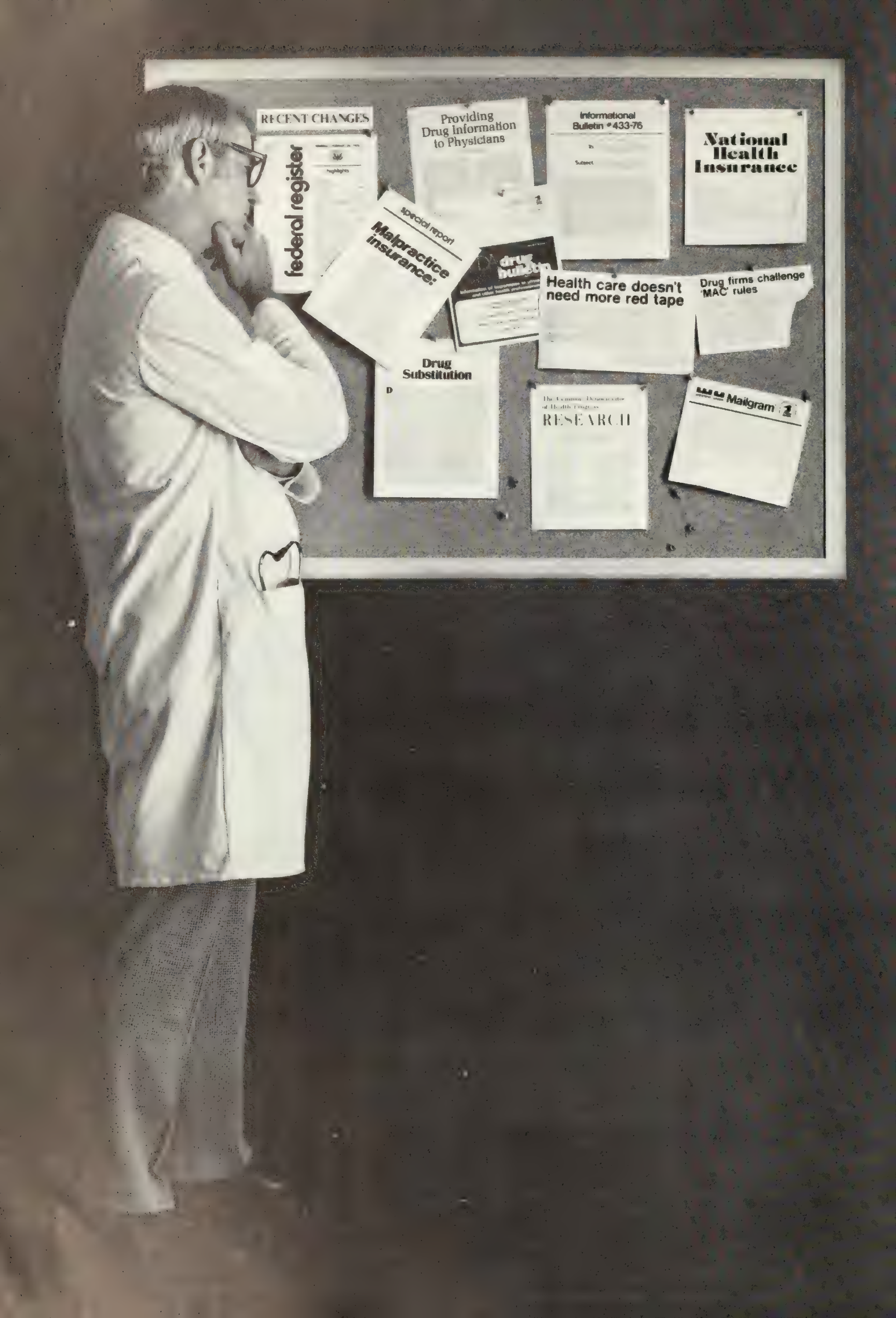
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

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COMMENTARY

Put rural kids in medical schools; we'll get them back

Doctor Morgan

By Dale K. Morgan, MD
South Haven

It seems that whenever medical care is discussed in rural areas these days everybody wants to know what happened to the family doctor. The magnitude of this problem is pretty widely appreciated especially in Michigan where every rural county is dangerously short of primary physicians.

Our rural people are very angry and resentful about this because (1) they know our schools graduate well over 500 doctors a year and (2) they know that they pay out $80,000 in taxes for each graduate and (3) the last doctor we got in our area from a Michigan medical school arrived 16 years ago!

What is behind all this? Figures can be tricky but there is evidence that in the past several years about 65% of all our graduates left Michigan and thus do not practice here. At this point we might consider the contrast in economic conditions in Michigan in the past as compared to the present and near future. We are undoubtedly going to lose even more. If we are to assume that the purpose of our Michigan medical schools is to provide doctors for the people of Michigan then it appears that someone has been "asleep at the switch."

Rural areas not appealing

Obviously our graduates do not find Michigan appealing and they are especially repelled at the idea of practicing in our rural areas. We all know that this is a nationwide phenomenon and several remedies have been proposed. The most notorious, of course, is Teddy Kennedy's National Medical Manpower Act which is perilously close to enactment.

We all agree that the rural doctor shortage is a dreadful disgrace. And Teddy would have us believe that only he can save the poor people. Other politicians and do-gooders have similar proposals all of which seem to involve forcing something unpleasant down the throat of the medical community and/or spending huge sums of money for hairbrained and unmanageable programs.

The real solution to the problem is deceptively simple and well known to every old rural GP. It centers around the notion that we are admitting a lot of wrong people to our medical schools. The management people in our medical schools have been spending millions of our tax dollars to turn out, year after year, essentially a useless product for their employers — the people of Michigan. How long would these people work for General Motors?

When you ask the deans why we are getting such a miniscule return on our investment they will usually explain that they must choose the most qualified applicants. No matter that these qualified applicants: (1) promptly leave the state for warmer climes and (2) really don't amount to much as medical students anyway.

The big trouble with our deans is that they don't know a good man when they see one. They seem to have difficulty distinguishing among people who are really educated and con artists who present magnificent grade point averages. Their idea of medical talent leads them to select mamma's boy bookworms from the big cities who have been exhaustively tutored in the methods of getting high grades in any and all exams. They routinely select students from affluent suburbs of the larger cities who are highly trained in the sharp competitive business of hustling grades.

All this activity of course selectively eliminates applicants from our relaxed, non-competitive rural schools. Our scholars are not organization men and by the time they wise-up to the necessity of forgetting education in order to cage grades they are lost in the competitive rat race with a grade point average too low to get by the computer.

Doctors practice where they want to live

I contend that doctors practice where they want to live and that most people elect to live in the environment in which they were raised. City youngsters will never come to the country. If we are ever to get rural doctors we must make doctors out of our rural material. We must have a quota based on population which will permit rural areas to sponsor their own medical students and by-pass the school admissions people.

After all, it is our health, it is our money and those are our medical schools. Who is to tell *us* that they know better than we who is qualified to render medical care to our rural people?

If we put those kids into those schools, we will get them back!

Dr. Morgan is a family physician.

Physicians should identify teenage alcoholism

By Victor R. Stoeffler, CSW
Ann Arbor

Alcoholism among youth between the ages of 12 and 17 is found in one out of 70 persons, and is increasing.

Alcohol, the drug of choice among youth, is used to gain quick maturity, enhance shallow peer relationships, and duplicate parental behavior. Alcoholic beverages are readily available through peers, are relatively inexpensive and more reliable than street drugs which were previously more popular.

Parents significant factor –

The most significant factor shown in many studies about problem drinking behavior among youth is the drinking behavior of their parents.

Pediatricians and family practitioners would do well to identify the problem among their patients.

Because we know that youth who are living in families where alcoholism already exists are at high risk, special attention should be paid to prevent their abuse of alcoholic beverages.

This is where physicians, especially pediatricians and family practitioners, can play an important role. They should ask, probe, and isolate the problem just as if they were looking for a disease with other psychological or organic causes. Physicians should be aware of alcoholism in a family with young children, recheck this on a continuing basis and evaluate family attitudes about the use of alcohol.

Our present system of health care and human services is not prepared to identify and treat the problem. Most physicians, particularly those caring for youth, are unwilling to probe into the life of a child or family in which the problem exists — unwilling, because they are frightened of what they will find and because they are not in a position to help the young person and the family. A *few* community agencies dealing with substance abuse are working with youth and their drinking problems,

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Mr. Stoeffler is assistant professor of maternal and child health, School of Public Health, The University of Michigan, Ann Arbor.

Malpractice cases shouldn't be left to the courts – they're too technical

By Peter A. Davis
Ann Arbor

(The following is taken from the text of a talk before a recent meeting of the Washtenaw County Medical Society.)

Even though doctors have fared better overall at the hands of our courts than anyone has expected, that is going to change.

It will change because malpractice cases are too technical and too important to be left to the courts, which, unfortunately, are no longer geared to deal with anything other than routine cases having common principles.*

In the 1974-75 fiscal year the 44 Circuit Courts in this state had over 250,000 cases pending before only 139 judges. Docket congestion and the unpredictability of the system are not dealt with effectively by the insurance industry which is perhaps too archaic to insure the medical profession on a fault basis. While this may make settlement a desirable *short term* goal in an individual case, it creates undesirable long range problems for the economics of malpractice defense.

Much can be said, therefore, for the proposition that medical malpractice cases do not belong in the courts at all. The patient who suffers a bad medical result with disastrous injuries, whether that is the product of negligence or not, ought to be compensated in a compassionate society.

We should have a true no-fault system for injuries to patients. The same medical no-fault system ought to compensate parents who give birth to mongoloid, deformed or retarded children. No individual and no family should bear the entire burden of ill-health, whether accidents of birth or accidents of the health care delivery system.

Where it can be shown that the physician is responsible the medical societies and the licensing authorities can deal with that appropriately.

**For years we have advocated unjamming the court system by getting rid of the routine criminal and routine divorce cases. Instead those cases have multiplied enormously. Perhaps it makes more sense to leave the court system to flounder with its routine cases and find a better way to resolve the important cases elsewhere.*

The author is an attorney with the firm of Hooper, Hathaway, Fichera, Price and Davis of Ann Arbor, and is legal Counsel to the Washtenaw County Medical Society.

How we physicians can work to control health care costs

Doctor Klicka

(The following is excerpted from a talk delivered by the author to a recent hospital staff gathering in Ypsilanti.)

By Karl G. Klicka, MD Wayne

Let me make a few observations about what I believe we must do to make a proper case for the health service industry in the matter of cost containment. Others are busy expounding on their opinions about it. It is time we have our say.

Certainly the time has come and gone that we can make a case for ourselves on any basis except one of complete honesty. We cannot talk cost containment unless we practice containment — hospital administrators and physicians alike. We must recognize that as we attempt to make a case for the provider we are taking a defense position and in so doing we must be willing to admit to any errors we may have made in the past and to be willing to expose ourselves as completely as possible.

Hospitals must increasingly expose the details of their operation to the public and to those people who call themselves consumers, for they are our sharpest judges. We must tell them as often as they will listen what the elements of cost contain. Physicians unfortunately will be held suspect by the general public, many of whom find it difficult to accept the fact that a physician deserves a substantial income for the work that he provides in rendering health services.

Please remember that there is a difference between substantial and unreasonably high. If your income is substantial but justified you should have no problem in defending it, but if it is unreasonably high and you cannot defend it publicly then you have a personal problem.

The big issues

But the big issues as I see them in this regard are patient demand and over-utilization.

As health care services are made more easily available, unfortunately, the dilemma that faces the providers

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ALCOHOLISM/*Continued*

but most are not prepared to meet the needs of this population.

Treatment and prevention

Programs to counter the problems of alcohol abuse among youth should contain aspects of treatment and prevention. If some of the suggested programs and resources are not available within a given community, pressure should be exerted on the local mental health clinic, the council on alcoholism or the child and family service agency to establish them.

In an effort to attack the drinking problems of youngsters, programs should contain components of treatment and prevention. Parents, interested citizens, teachers, physicians, and social workers should encourage the establishment of treatment programs such as Alcoholics Anonymous groups for youth only, or youth recovery homes which offer detoxification and rehabilitation. These could be modeled after the drug rehabilitation centers. Traditional individual or group therapy might be arranged but youngsters will usually make progress when being treated with peers who are having the same problem.

If at all possible, treatment of the youthful alcoholic should include the counseling of parents and optimally, the entire family.

Equal to treatment must be programs of early intervention and prevention. It is of crucial importance for young people to be capable of making sound, rational decisions about the use of alcohol; and broad comprehensive programs of education and information about alcohol can help to achieve this. The most reasonable place to do this is through health education or education for living classes in elementary, junior high and high schools. Enlisting the support of parents to push for these programs in schools should also be a part of the early intervention against alcoholism among youth.

of these health care services of how to cope with the unrestrained demand as yet has not been satisfactorily resolved.

In addition, the complex factors that involve the providing of care today have resulted in escalating costs that appear well-nigh impossible to control, and we now find ourselves in the dilemma of trying to provide health services in the face of such factors.

In order to be helpful in trying to resolve the dilemma faced by health care service providers of how to control costs in the face of ever-increasing demands for services, all of us need to study the problem at greater length, to become involved and then to become articulate in expressing those truths of the situation of which we are aware.

I certainly am no Solomon and don't presume to know the answer to our dilemma but I do encourage you to foresake despondency and to do what you can to attack the problem with facts.

Use the facts

And as you become more acquainted with the facts don't hesitate to be forceful spokesmen with those facts. Our legislators are subject to pressures from all of us — you and I and everyone else in our communities. We have just as much right to attempt to influence our legislators along the lines that we think are proper as others may have to influence them along the lines they think are proper.

Also, bear in mind that we do have official spokespeople who are working hard at the task of representing us — specifically the Michigan State Medical Society, the American Medical Association, the Michigan Hospital Association and the American Hospital Association. In my judgment these organizations are telling the facts as they are and they are persistent. They need our support. They need our understanding.

Maybe, just maybe, if we keep at it and continue to make an honest case for the health care profession the public will begin to believe us. And that, in essence, is my message to you.

Doctor Klicka is executive director of the Peoples Community Hospital Authority serving 18 cities and five townships in the metropolitan Detroit area.

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cally, so do our psychological abilities unfold in a somewhat concerted relationship with age. Stages of transition can be identified, which we usually list as birth, infancy, early years, elementary school age years, adolescence, adulthood, middle age, senescence and the final stage of all, death.

Crisis. All normal transitional periods are situations of steady and involved change, and therefore designated as developmental or normative crises. Each of these transitions has a beginning, a time of working through tasks and resolution of problems, and a fairly distinct outcome.

Superimposed on the normative years, there are also a myriad of events and happenstances which are not as easily predicted. These we call life or existential crises.

A life crisis usually does not last more than six weeks. It produces such immediate response, and it calls for such quick changes, that some kind of resolution needs come about in a short period of time. Even if nothing is done to face the crisis, a solution of sorts, usually far from ideal, would occur by default.

What is the most important factor influencing favorable or disfavorable outcomes of crises?

One particular factor appears to be very significant, and it is the kind of help the person receives at a time of trouble. Because the crisis situation, by definition, is a fluid state, a little bit of help goes a long way. The individual who gains enough human support to overcome the problem comes out of this emotional ordeal strengthened in his ability to cope, and with a more secure and grownup outlook.

Specific Steps

Several years ago, Gerald Caplan, MD, a community psychiatrist at Harvard, showed that there are a number of activities needed to help someone out of a crisis situation, towards a constructive outcome.

Every transitional period requires appropriate human response, by the one involved, in the form of being able to identify and carry out a number of psychological tasks. Whether the outcome emerges on the opportunity side of the ledger, or on the more negative one of succumbing to the challenge, may depend on the

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Crisis intervention a technique physicians should master

By Jose J. Llinas, MD
Gainesville, Fla.

One of the most hopeful changes occurring in psychiatric practice in the last 20 years has been the development of *crisis intervention,* a form of brief psychotherapy which has proven immensely helpful to people in difficulty, whether they are acute mental patients, or reasonably healthy people facing adverse or stressful situations.

The technique of crisis intervention, when properly understood and used, is a very powerful tool in the hands of any professional, including physicians.

To master the basic concepts, it is necessary first to define mental health or normal adjustment; second, to become familiar with the related concept of emotional maturity and how it comes about; and, finally, to study the specific steps to be taken by the physician to provide this type of psychological aid. In a surprising number of cases, the approach is so potent that it turns out to be either the definitive or the only type of psychological care needed.

Doctor Llinas

Mental Health

One of the best definitions of mental health was given by Sigmund Freud. "A normal person," he stated, "should be able *to love* and *to work.*"

Nowadays, to the telling dictum of the psychoanalyst, we would have to add another important dimension — the normal person's ability to *play,* to relax, to immerse himself from time to time into pleasurable activities and forget about his otherwise important everyday cares and concerns.

Emotional Maturity

A person who can work well, who is warmly interested in others as well as himself, and who doesn't always need to take himself very seriously, is usually described as a mature person.

Accepting that there is a wide range of normal conduct, we can identify such a person because he acts grown up, most of the time, and shows mature behaviors and attitudes.

A mature person is independent and reliable. He shows tolerance. He is insightful. A mature person has a good sense of values, is comfortable with and accepting of his own sex; is reality oriented, productive, optimistic, contented.

How Does Maturity Develop?

As we grow and develop physidoctor's aptitude in applying the following guidelines, with the caveat that not all steps have to be taken with all patients. These rules or guidelines, however, offer a chance to make sure one is doing everything possible to help, and that the therapeutic thrust is going in the right direction.

1. Confront The Danger

It is necessary to help the person face and confront the danger, by encouraging a frank acceptance of the fear and discomfort which sort of "comes with the territory" in a situation of crisis. And to understand that, contrary to what the patient might have believed all his life, it is natural to be upset in such a situation, and there is nothing unusual about it. Accepting that one is under some peril is not a confession of helplessness, but rather the first step in fighting back the problem.

2. Confront In Tolerable Doses

A somewhat natural corollary of helping the patient face the danger, is that this cannot be done in a relentless, non-supportive, insensitive manner. A person in a perennial state of alert vigilance will soon be morally and physically exhausted. We all need relief from time to time, particularly during acute and difficult situations. One of the best ways to do this is to try to cut the problem down to size, so that one can attack one particular aspect at a time, and temporarily forget about the rest.

3. Find the Facts

Though this important step is implicit in the first two rules, it is probably the most commonly ignored one in practice.

4. Do Not Give False Reassurance

Within limits, a supportive approach is excellent. We must be careful, however, of the treacherous pitfall of blanket reassurance, which tends to wax unrealistic sooner or later, and does not assist in problem solving.

Until the facts are clearly sorted out, and one begins to see what can be done to start solving the problems, it is a lot more supportive to convey to the patient that his physician has faith in the man's ability to handle the situation, with appropriate help. The doctor is not on the side of ineffective denial, but rather encouraging the patient's executive functions.

Undergoing major surgery can't be an altogether pleasant experience. Talking ahead of time about his fear and apprehension makes the patient more able to accept the possible discomforts in a more realistic vein; like turning a powerful beam of light into a foggy night, it cuts unseen terrors down to human, manageable proportions.

5. Do Not Encourage Blame

A tendency to project blame on to others, or to accuse oneself for the mishap, is very common when there is trouble. The frightened patient has to be assisted to see the difference between heaping shovelfuls of blame upon oneself or others, as opposed to taking responsibility for the consequences of human actions.

We need to help the patient and his family appreciate the falsity of either approach naming scapegoats or sinking into quagmires of unreasonable guilt. We must help them be realistic in understanding and taking appropriate responsibility for those aspects of the situation which are under their or other people's control; they also have to accept courageously those facets of the problem which are beyond human influence.

6. Assist With Everyday Tasks

While it often seems to the individual undergoing a crisis that everything else in the world has stopped, except for the turmoil around him, this is hardly the case. Life goes on. Life must go on.

When people are upset, however, tending to the myriad details of everyday life is harder, confusing, at times impossible. Helping with these practical problems is one of the most positive things that we can do to succor the individual.

7. Help the Person Accept Help

This guideline seems at once simple, and self-evident. Both appearances are deceptive. Precisely because of the normal emotional turmoil that the person in crisis experiences, and the misguided feelings of guilt, fear, shame, it may be very hard to turn to another human being, which by definition is really the only realistic path.

It is basic to reach out to the person in crisis; to re-state and interpret the need for help not as a confession of weakness, but as the natural way to regain both emotional equilibrium and personal strength.

Helping a person accept help, without loss of self-esteem, is the cornerstone of the whole crisis approach.

Summary

Crisis intervention is a powerful technique to help people become more grown-up, and cope better with their human problems.

It involves understanding the stage of development and the particular life circumstances of the person as completely as possible; and identifying the important tasks the individual has to carry out.

The specific problem-solving steps consist of aiding the person to face the danger; finding the true facts, without blaming himself or anyone else. Most important, we need to help the person accept human help and friendly support, with respect for his own ideas, and his basic dignity as a person.

Doctor Llinas is associate professor of psychiatry, College of Medicine, University of Florida, Gainesville, and also director, North Central Florida Community Health Center. He formerly was psychiatric director of the Lansing Community Mental Health Board.

Physicians must ensure good infant tooth development

By Chris Valmassei, Special to **Michigan Medicine**

Dental caries is the most common disease of mankind.

Frederick Margolis, MD, Kalamazoo pediatrician, charges physicians with the responsibility of giving lifetime protection to the deciduous and permanent teeth.

"Since the deciduous teeth are calcified by age one, and calcification of the permanent teeth begins at birth and is complete at age eight to 10 years, supplemental fluoride must be prescribed in the first 10 months of life and continued until all the permanent teeth have erupted. The dentist obviously has no opportunity to become involved during this critical time of calcification since it is unusual for children to begin dental care before four years of age and all too few see a dentist even at that age," Doctor Margolis says.

He is part of a group of physicians and researchers who conducted a 10-year study of the effects of fluoride on reducing caries in infants before professional dental care begins.

About 1,500 children, some from Kalamazoo, were included in the study from infancy through 10 years. Annual counts of caries and numbers of children with no caries were tabulated for deciduous teeth, permanent teeth, and six-year molars. The results indicated a consistent diminution in caries activity for both deciduous and permanent teeth for groups ranked from the greatest retardation of caries to least: infant fluoride group, water fluoride group, age-4 fluoride group, and controls.

"The lowest caries rate occurred when children were given fluoride from infancy either as a fluoride

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Doctor Margolis

supplement or in fluoridated water. Starting fluoride supplements at four years of age had no effect on the deciduous teeth and had limited effect on permanent teeth," Doctor Margolis said.

Individuals receiving fluoride from infancy will, throughout life, lose one permanent tooth for every four lost by those deprived of fluoride, he says. Dental caries is especially prevalent in the deciduous teeth and is in fact, the most common disease of childhood. Deciduous tooth loss and caries may have long-lasting effects on the growth of the maxilla and mandible, and on crowding and occlusion of the permanent teeth. Caries may also cause a great deal of pain and much reparative expense.

For the successful control of dental caries, it is incumbent on physicians caring for children to determine the fluoride need of each patient, Doctor Margolis says, to interpret the value of fluoride to the patient, and to check the continued use of fluoride with the same concern that he gives to the immunization program of each patient.

This responsibility involves some practical considerations:

(1) Supplemental fluoride should not be prescribed to children who drink fluoridated water except in the case of the breast-fed infant. (Breast-fed babies get negligible fluoride from breast milk and have an average intake of only 15 ml of tap water daily.) (2) "Incorporation of a fluoride in a dentrifice," to quote from Accepted Dental Therapeutics, "is in no way comparable to fluoridated drinking water." (3) Sugars ingested at mealtime do not increase caries rates. However, if sugar is contained in a sticky vehicle and consumed between meals, thus permitting prolonged exposure of the teeth to the sugar, caries rates are increased.

"The use of fluoride supplements is a realistic preventive technique," Doctor Margolis said. "If this nutrient is provided during the formative period of tooth development, lifetime benefits will result. Dental caries and tooth loss are a universal source of misery and expense, and the physician is now in a position to provide methods of inexpensive and effective prevention.

"The effort from the physician is minimal and the results in caries reduction are for life," Doctor Margolis concluded.

Must MDs seeking staff privileges disclose insurance information?

The following is reprinted from a question and answer column prepared monthly for the national publication, Hospitals, *by John D. Porterfield III, MD, director, Joint Commission on Accreditation of Hospitals.*

Does the Joint Commission require that a physician seeking medical staff appointment or reappointment disclose the name of his malpractice insurance carrier, the amount of his coverage, and his past or recent malpractice experience?

The standards of the Joint Commission require only that the hospital and its medical staff establish a procedure for the fair evaluation of the qualifications and the competence of each individual. The procedure should be fair and impartial, broad enough to recognize professional competence, and strict enough to safeguard patients. The recommendations on appointment and reappointment must depend upon a thoroughly documented evaluation of the qualifications and performance record of each person considered. The Joint Commission neither requires nor opposes a provision that malpractice coverage and experience be divulged for either appointment or reappointment review. Requiring such disclosure is a matter of local option and of local legal procedure. If disclosure is to be required by local decision, the JCAH would expect it to be implemented impartially and in a nondiscriminatory manner for all applicants and staff members.

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on medical and
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welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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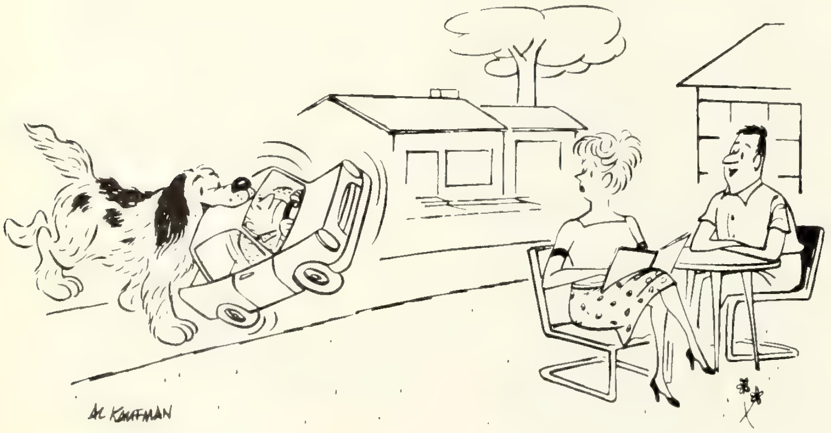
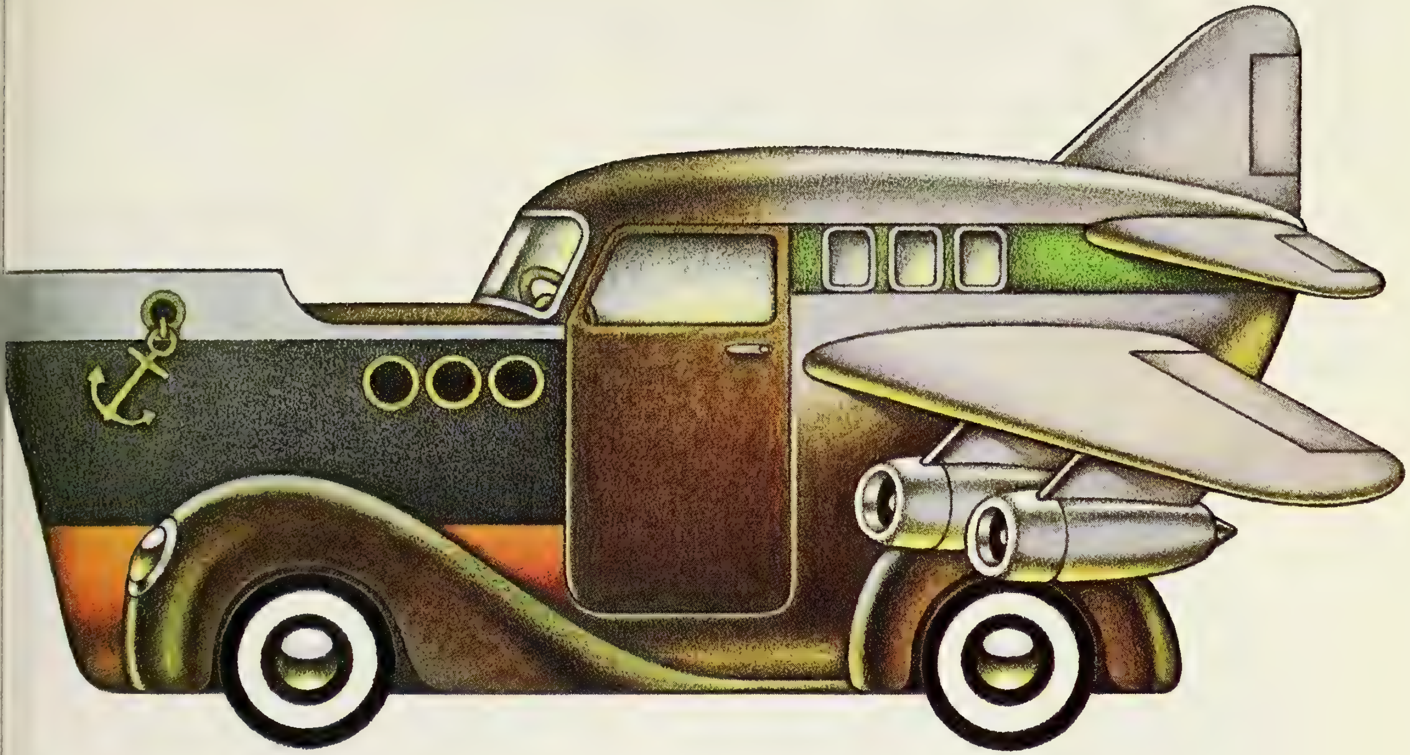


"Well, he finally caught one!"



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Up to 24 hours of effective control with a single dose...in nausea, vomiting and dizziness associated with motion sickness.

Dosage: 25 to 50 mg. 1 hour before travel.
Available on prescription only.

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CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*

LOWERS BLOOD PRESSURE
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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness dizziness, headache, dry mouth; anaphylaxis rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea constipation, other gastrointestinal disturbances Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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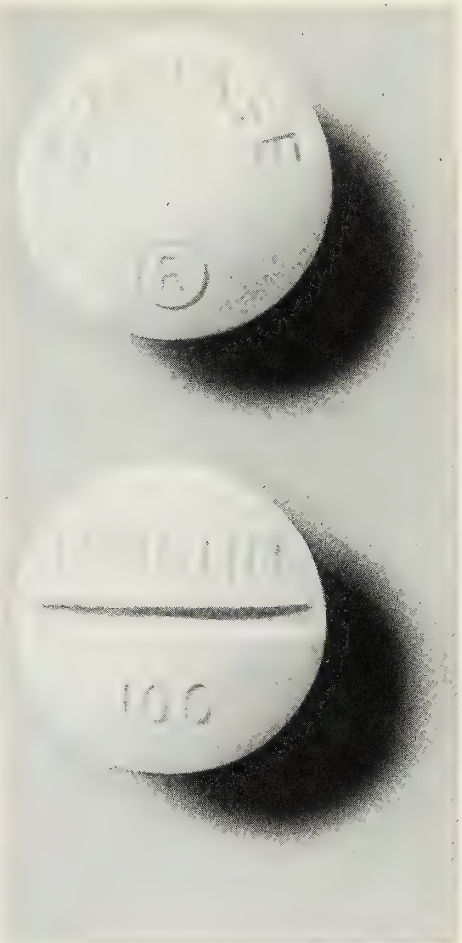

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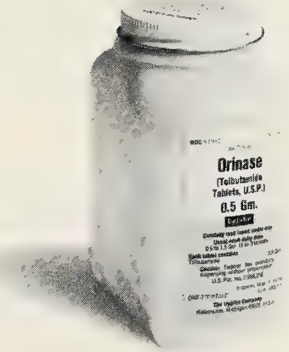

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WHEN ANXIETY INTERFERES.

The cardiac patient and anxiety.

"The [cardiac] patient is anxious about minor symptoms, about the implications of his diagnosis, and about real or imagined limitations of function."*

The worst is over. The cardiac patient is out of the acute stage, out of the hospital, and well on his way to recovery. How quickly he comes back to near normal functioning may depend on his psychological as well as his physical rehabilitation.

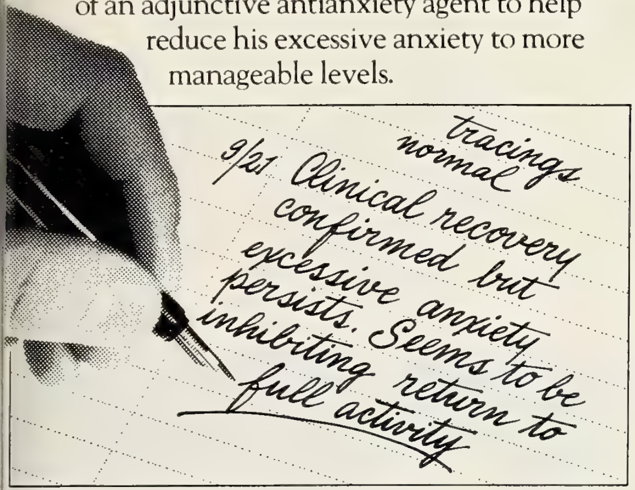
Clinical anxiety, for example, may be one reason for prolonged recuperation following cardiac healing. Yet anxiety can sometimes be beneficial in facilitating patient compliance.

The patient who is realistically concerned about resuming his precoronary functioning may be highly motivated to adhere to his rehabilitation regimen. However, the cardiac patient with *excessive* or unresolved anxiety may be so fearful of future heart failure that he refrains from your prescribed regimen. These excessively anxious cardiac patients eventually present the same clinical characteristics as patients deconditioned by bed rest.

Excessive anxiety can interfere with patient management

When excessive anxiety diminishes your

atient's ability to participate fully in his rehabilita-ion program, your counseling and reassurance are ften sufficient. But when his anxiety is so great that t actually interferes with his ability to listen and respond, you may want to consider the addition of an adjunctive antianxiety agent to help reduce his excessive anxiety to more manageable levels.


tracings normal
9/21 Clinical recovery confirmed but excessive anxiety persists. Seems to be inhibiting return to full activity

Librium® (chlordiazepoxide HCl) an effective adjunct to your reassurance and counseling

Safety: Librium has a highly favorable benefits-to-risk ratio and a wide margin of safety. Because of its low incidence of side effects, it is regarded as one of the safest antianxiety agents available. And Librium does not adversely affect the cardiovascular system. See complete product information for warnings, precautions and adverse reactions.

Performance: Hundreds of clinical trials, thousands of published papers, and millions of patients comprise the record of performance for Librium.

Concomitant use: Of special significance in treating the cardiac patient already taking multiple agents is the fact that Librium is used concomitantly with most primary medications, such as cardiac glycosides, diuretics and antihypertensives.

*Zohman BL: *Geriatrics* 28:110-119, Feb 1973

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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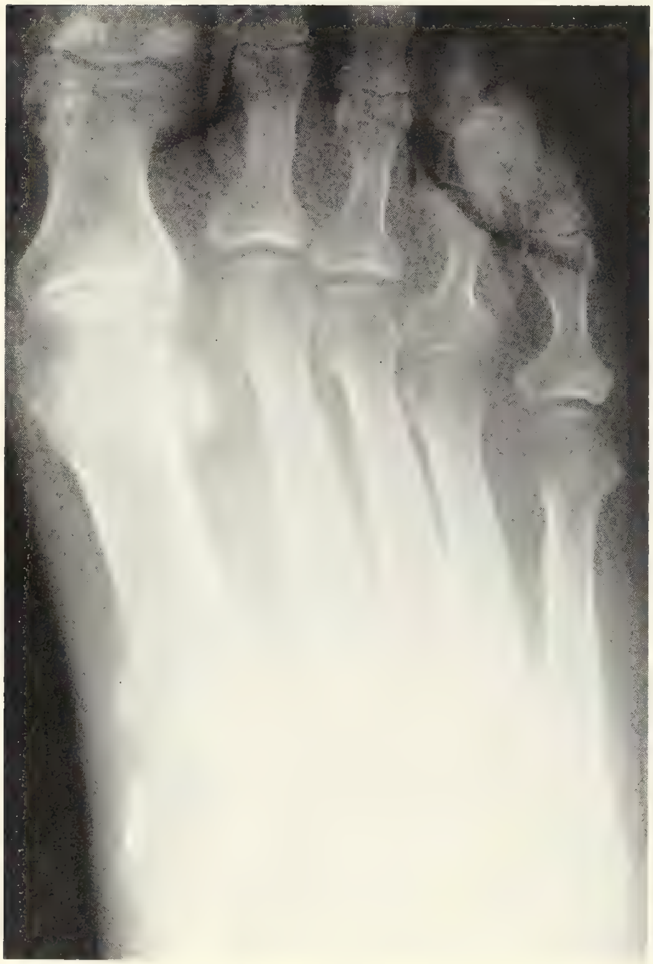
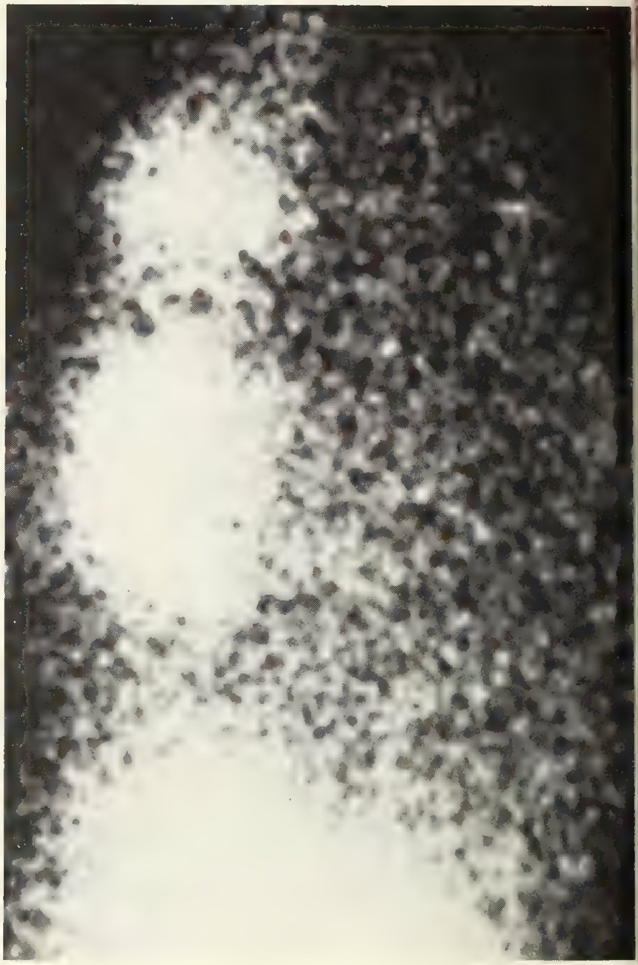
THE ANXIETY-SPECIFIC

VISUAL FOCUS ON ACUTE GOUTY ARTHRITIS



Foot of patient with acute gouty arthritis as seen by conventional x-ray.



Scintiphotogram of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

THERAPEUTIC FOCUS
ON

CAPSULES, 25 mg and 50 mg

INDOCIN®

INDOMETHACIN | MSD)

*helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients*

INDOCIN is a potent drug with anti-inflammatory, antipyretic, and analgesic properties. It should not be used in conditions other than those recommended. Although INDOCIN does not alter the progressive course of the underlying disease, in selected patients with acute gouty arthritis it has been found highly effective in relieving pain and in reducing fever, swelling, and tenderness.

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SHARP&
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For a brief summary of prescribing information, please see following page.

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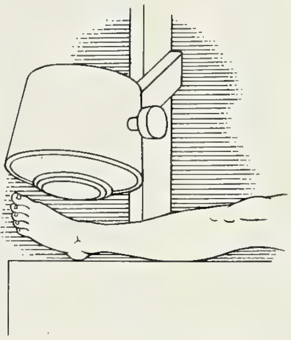
addendum

Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

INDOCIN®
(INDOMETHACIN | MSD)

helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients

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IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestina lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Drug Interactions: Although INDOCIN has not influenced the hypoprothrombinemia produced by anticoagulants, patients on anticoagulant therapy should be observed closely for alterations in prothrombin time. In patients receiving probenecid, plasma levels of indomethacin are likely to be increased and a lower total daily dose of INDOCIN may produce a therapeutic effect; increases in the dose of INDOCIN should be made cautiously and in small increments.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura may occur rarely. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, a rapid fall in blood pressure resembling a shock-like state, angioedema, dyspnea, asthma, angiitis, pruritus, urticaria, skin rashes, purpura.

Ear Reactions: Hearing disturbances—deafness reported rarely; tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in single-unit packages of 100 and bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

Category 1 Programs

Michigan Medicine each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

DATE: Aug. 24, Constrictive Pericarditis
LOCATION: Stanley Wing Auditorium, Ingham Medical Center, Lansing
SPONSOR: Ingham Medical Center and Michigan State University
FOR: All interested physicians
COST: None
CONTACT: Ingham Medical Center**
APPROVED FOR: 1 Hours of Category I Credit

* * *

DATE: August 28-31, Current Topics in Medicine
LOCATION: Grand Hotel, Mackinac Island
SPONSOR: U-M Office of Intramural Education
COST: $150/$55 per day
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 11¼ hours of Category I credit

* * *

DATE: Aug. 31, Patient Management of Multi-Systems Trauma
LOCATION: Stanley Wing Auditorium, Ingham Medical Center, Lansing
SPONSOR: Ingham Medical Center and Michigan State University
FOR: All interested physicians
COST: None
CONTACT: Ingham Medical Center**
APPROVED FOR: 1 Hour of Category I Credit

* * *

DATE: Sept. 1, Venereal Disease Program
LOCATION: Grand Hotel, Mackinac Island
SPONSOR: Michigan Health Officers Association
FOR: All interested physicians
COST: $5
CONTACT: James M. Davis, MD, Van Buren County Health Department, Box 307, Hartford, MI 49057
APPROVED FOR: 4 hours Category I credits

* * *

DATE: Sept. 1, 8 and 15, Infectious Diseases
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan, Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 1 hour of Category I credit

* * *

DATE: Sept. 2-Nov. 11, Clinical Endocrinology and Infertility Seminars
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, 48236
SPONSOR: Saint John Hospital
FOR: Internal Medicine — OB-GYN — Family Physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 20 Hours of Category I Credit

* * *

DATE: Sept. 6-Nov. 8, Seminars in Perinatology
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, 48236
SPONSOR: Saint John Hospital
FOR: All interested physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 20 Hours of Category I Credit

* * *

DATE: Sept. 7, Challenges of Psychiatry in a General Hospital Setting
LOCATION: Stanley Wing Auditorium, Ingham Medical Center, Lansing
SPONSOR: Ingham Medical Center and Michigan State University
FOR: All interested physicians
COST: None
CONTACT: Ingham Medical Center**
APPROVED FOR: 1 Hour of Category I Credit

* * *

DATE: Sept. 7-Nov. 9, Oncology Today
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, 48236
SPONSOR: Saint John Hospital
FOR: All interested physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 20 Hours of Category I Credit

* * *

DATE: September 10-11, Anesthesiology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $60
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 8½ hours of Category I credit

* * *

DATE: Sept. 13-17, Third Annual Family Practice Review
LOCATION: Scott Hall, WSU
SPONSOR: Department of Family Medicine, WSU
CO-SPONSOR: Michigan Academy of Family Physicians
FOR: Family physicians — interested physicians

CATEGORY I COURSES/*Continued*

COST: $150.00
CONTACT: Sally Bates, Department of Family Medicine, WSU (313) 577-1420
APPROVED FOR: 40 Hours of Category I Credit

* * *

DATE: September 15, Otolaryngologic Problems in Family Practice
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: Michigan Academy of Family Physicians
COST: $60
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 7 hours of Category I credit

* * *

DATE: September 17-18, Psychiatry Conference, "Diagnosis and Management of Adult Psychiatric Syndromes"
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $80
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: Sept. 17-18, Therapeutic Gastrointestinal Endoscopy
LOCATION: Michigan Inn, Southfield
SPONSOR: Michigan Society for Gastrointestinal Endoscopy
CO-SPONSOR: American Society for Gastrointestinal Endoscopy
FOR: All interested physicians
COST: $125 for members; $150 for non-members; $75 for physicians-in-training
CONTACT: William P. Maloney, Executive Secretary, American Society for Gastrointestinal Endoscopy, 6 Beacon Street, Suite 620, Boston, Mass 02108
APPROVED FOR: 10 Hours of Category I Credit

* * *

DATE: Sept. 22, Allergy & Immunology Seminar
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, MI 48236
SPONSOR: Saint John Hospital
FOR: Allergy — Immunology
COST: $50
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 7 Hours of Category I Credit

* * *

DATE: Sept. 22-24, Blood Coagulation Techniques
LOCATION: Towsley Center for Continuing Medical Education, Ann Arbor
SPONSOR: Office of Intramural Education, Dept. of PGM/HPE
COST: $150
CONTACT: Office of Intramural Education, Dept. of PGM/HPE, University of Michigan
APPROVED FOR: 19¼ Hours of Category I Credit

* * *

DATE: Sept. 22-24, Recent Advances in Neurology
LOCATION: McGregor Memorial Center, Wayne State University
SPONSOR: Wayne State University Department of Neurology
FOR: All interested physicians
COST: $150
CONTACT: Beverly Wolf, Department of Neurology, 3990 John R, Detroit, 48201
APPROVED FOR: 18 Category I credit hours

* * *

DATE: Sept. 28, New Concepts in Nutrition
LOCATION: Hospitality Inn (Cascade Road) and Butterworth Hospital, Grand Rapids
SPONSOR: MSU College of Human Medicine, GRAMEC and American Society for Parenteral and Enteral Nutrition
FOR: All interested physicians
COST: $35.00
CONTACT: Richard Dean, MD, (616) 459-2837 GRAMEC
APPROVED FOR: 9 Hours of Category I Credit

* * *

DATE: Sept. 28, Recent Advances in the Pathophysiology and Therapy of Low-Flow (Shock) States
LOCATION: Stanley Wing Auditorium, Ingham Medical Center, Lansing
SPONSOR: Ingham Medical Center and Michigan State University
FOR: All interested physicians
COST: None
CONTACT: Ingham Medical Center**
APPROVED FOR: 1 Hour of Category I Credit

* * *

DATE: Sept. 29, Infectious Disease Symposium
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 4 hours of Category I credit

* * *

DATE: Sept. 29-Oct. 2, Acute Respiratory Failure: Mechanisms and Management
LOCATION: Towsley Center, U of M, Ann Arbor
SPONSOR: American College of Chest Physicians
CO-SPONSOR: University of Michigan Medical School
FOR: Thoracic Surgeons
COST: ACCP Members: $160, Nonmembers: $185, Residents, Nurses & Therapists: $125
CONTACT: American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068, (312) 698-2200
APPROVED FOR: 28 Hours of Category I Credit

* * *

DATE: Oct. 1-3, Regional Meeting

— **American College of Physicians**
LOCATION: Hidden Valley Resort, Gaylord
SPONSOR: American College of Physicians — Regional
FOR: All interested physicians
COST: $15 for members; $18 for nonmembers; No charge for physicians in training
CONTACT: B. C. Payne, MD, (313) 763-1202
APPROVED FOR: 13½ Hours of Category I Credit

* * *

DATE: October 5, Continuing Pathology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: Undetermined
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: October 12-13, Diabetes Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $60
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 13½ hours of Category I credit

* * *

DATE: October 14-16, Family Practice Review
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: Michigan Academy of Family Physicians
COST: $170
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: October 19-21, Cardiology for Internists
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $170
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

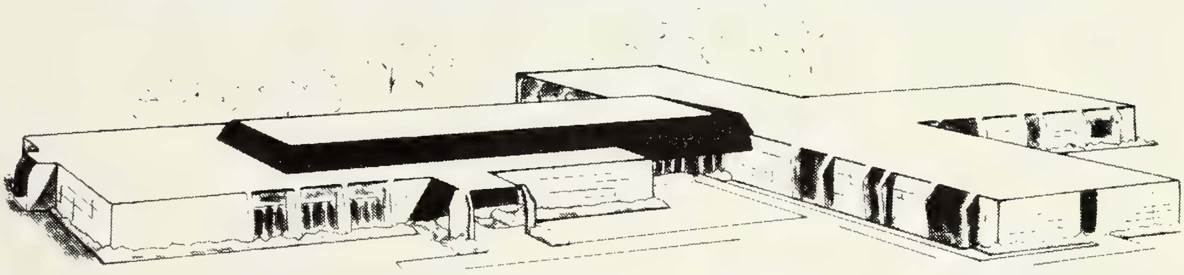
DATE: October 22-23, Psychiatry Conference, "Common Problems in Child and Adolescent Psychiatry"
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $80
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: Oct. 28-30, The Human Vagina: biological and clinical aspects.
LOCATION: Wayne State University
SPONSOR: WSU School of Medicine
FOR: Gynecologists, Family physicians
COST: $100
CONTACT: WSU
APPROVED FOR: 45* pending Hours of Category I Credit

* * *

FOREST VIEW PSYCHIATRIC HOSPITAL



Jack N. Carr, MD, Medical Director

Located on six beautifully wooded acres, *FOREST VIEW HOSPITAL* is Michigan's newest private psychiatric facility, specializing in short term intensive treatment. Comprehensive adjunctive therapy, including occupational and recreational therapy is emphasized. The prime goal of the hospital personnel is to aid the patient in coping with his illness and return him to community life as soon as possible. Licensed by the State of Michigan, Department of Mental Health, Accredited by the Joint Commission of Accreditation of Hospitals, Participant in Medicare and Medicaid.

Full Blue Cross participation.

4520 Cascade Rd. SE
Grand Rapids, Michigan 49506
Michael H. Payne, Administrator
616-942-9610

The following have been accredited by MSMS Commission on Continuing Medical Education as of June 9, 1976.

Organizations:

Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Grace Hospital, Detroit
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Saginaw Cooperative Hospitals, Inc., Saginaw
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
Wayne County Psychiatric Hospital, Eloise
Ypsilanti State Hospital, Ypsilanti

CATEGORY I COURSES/ *Continued*

DATE: November 8-9, Abnormal Hemoglobin and Thalassemia
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: American Society of Medical Technologists
COST: $70
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 15 hours of Category I credit

* * *

DATE: November 9-10-11, Michigan State Medical Society Annual Scientific Meeting
LOCATION: Hyatt Regency Hotel, Dearborn
SPONSOR: MSMS Committee for CME Programming
FEATURING: 36 Category I Courses, sponsored by statewide medical specialty societies and the MSMS Committee; taught by outstanding Michigan medical educators and practitioners and out-of-state authorities.
COST: $5 per credit hour for MSMS members; $10 per credit hour for non-members; no charge for residents and interns.
CONTACT: Herbert A. Auer, MSMS
APPROVED FOR: Category I credit; maximum during three days would be 25.
REGISTRATION: Registration forms, etc., will appear in early September MSMS Medigram.

* * *

DATE: November 17-18, Second Annual Pulmonary Seminar for Family Physicians
LOCATION: Harper/Webber Auditorium, Detroit Medical Center
SPONSOR: WSU School of Medicine, Departments of Family Medicine, Internal Medicine-Pulmonary Division, Pediatrics, and Div. of Postgraduate and CME; Michigan Academy of Family Physicians; American Lung Association of SE Michigan
FOR: All interested physicians
COST: $60.00
CONTACT: Miss Gibson or Mrs. Murray, American Lung Association of SE Michigan (313) 961-1697
APPROVED FOR: 16 Hours of Category I Credit

* * *

Continuing Courses

DATE: November 23, Continuing Pathology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: Undetermined
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: Every Friday, through June, 1977, Neurology Conference
LOCATION: 4 Morse Auditorium, Harper Hospital
SPONSOR: Wayne State University Department of Neurology
FOR: Internists, neurologists, neurosurgeons, pediatricians, family doctors
COST: None
CONTACT: Beverly Wolf, Department of Neurology, 3990 John R, Detroit, 48201
APPROVED FOR: 2 Category I hours

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**Mary Hollandsworth, Department of CME, Ingham Medical Center, 401 West Greenlawn, Lansing, MI 48910

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

consider the effect on coexisting glaucoma when you prescribe a vasodilator*

a vasodilator that has not been reported to raise intraocular pressure

VASODILAN®

(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

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*****Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Practice Management

How to hire top-flight office personnel

By R. Timothy Hogan
Ann Arbor

Do you have a frequent turnover of personnel in your office? Are you satisfied that your employees measure up to your expectations and fulfill the requirements of their job? If your answer to these questions is "yes" and "not quite," I suggest you take a closer look at your hiring, evaluation and training methods.

Most high volume medical practices today require the services of specialized personnel to perform a variety of duties related to the delivery of health care. This includes aides in your business office and clinical assistants.

It is always surprising how many times employees are hired without a job description or defined duties and are given no orientation or instruction by the physician, while the doctor assumes they know exactly what is expected of them. This is not fair to the employees and can be costly to the physician. Higher priority should be given to recruiting and hiring of personnel for the medical practice.

Sources of locating potential personnel might be the local medical assistants' society or nurses' association, placement counselors at nursing schools, hospitals, business schools and community colleges. Help also may be obtained from local employment agencies. Also consider using a blind ad in local newspapers or professional journals. Replies can be sent to a newspaper box number so you are not deluged with telephone calls.

Be specific when you advertise or recruit and ask for a resume to be mailed. Identify the position to be filled, and any particular job or personality requirements desired. You want only applicants who are qualified for the position you have available.

Call the best applicants for an interview and note their telephone manner. Mail them an employment application with a stamped return envelope to be returned prior to their interview.

You should obtain or develop your own employment application form with a list of questions relating to the applicant's background. This might include the following topics: personal information, education, prior employment for the past five or 10 years, special qualifications such as typing or business machines, collection control and insurance preparation, clinical experience such as nursing or laboratory skills and also health history, hobbies or interests and references.

The personal interview

Too many physicians fail to appreciate the value of the personal interview. In most cases the interview is too short, too hurried and lacks productive questions. Written applications provide good background information but a personal interview is more spontaneous and therefore more revealing and permits you to judge the applicant's emotional responses. The final interview should be conducted by the physician and not delegated to other staff members.

Are you looking for a dominant outgoing personality who will be a leader, or does the job description require a less aggressive individual who can take directions and would rather follow than lead. How the applicant's personality meshes with yours is an important consideration also. Here are some suggestions for successful interviewing: plan the interviews when you won't feel rushed, either after office hours or on your day off. Allow a half hour for each interview. Sacrificing your day off may not appeal to you, but remember it's cheaper than continually facing the hiring hassle.

When the applicant first appears ask yourself: Does the first impression please me? Remember this is what your patients will be thinking at a later date.

Conduct the interview in a relaxed atmosphere and talk to the individual in a conversational tone. Be sure to let the applicant do most of the talking. Have a few good interview questions in mind that will produce revealing answers and can't be answered with a yes or no. Don't write the answers down during the interview as this may put the individual in a defensive position. Save time to do this after the interview is concluded. The questions asked should reveal the applicant's reactions, opinions and emotions. People tend to follow patterns and you should attempt to determine if prior habits have become too firmly established to meet changing situations.

Bear in mind that the questions asked may be useless unless you have a careful evaluation of the answers you obtain. Hiring at best is no easy job and there is no foolproof method of interviewing. But careful listening on your part to what the applicant says and observation of the way the applicant says it will certainly help to weed out undesirable candidates. Also take the time to check with prior employers as to the individual's performance and attitude. All of this takes time; but it should increase your chances of obtaining the right person for the right job and reduce the personnel turnover in your office.

Mr. Hogan is a consultant with Professional Management, Black and Skaggs Associates, Ann Arbor.

The Michigan Cooperative Health Information System of the Michigan Department of Public Health has just released its complete findings of the 1973 Michigan Ambulatory Medical Care Survey. The Michigan survey was done to supplement the National Ambulatory Medical Care Survey that was conducted during the period from May, 1973 through December, 1975.

The following are some of the highlights taken from the report that was prepared by Richard G. Cornell, Feridun H. Ozgoren, and James A. Rutherford of the University of Michigan's School of Public Health, Department of Biostatistics:

Michigan statistics on office visits close to national figures

From the MSMS Bureau of Economics

An estimated 28.9 million visits were made to office-based "patient care" physicians in Michigan during May 1973-April 1974, resulting in an average of 3.2 visits per person per year. The Michigan visitation average is approximately the same as the national average of 3.1 visits per person per year for the 48 contiguous United States for which the estimated total for the year is 644.9 million visits. National figures are based on the results of the National Ambulatory Medical Care Survey (NAMCS) for the same time period.

In Michigan, 52.6% of all visits were made to general and family practitioners, 18.5% to medical specialists and 25.8% to surgical specialists. Nationally, the corresponding percentages were 40.4, 26.3 and 28.5, respectively.

Four classes of diagnosis accounted for approximately half of all visits: special conditions and examination without sickness, 20.3%; diseases of the respiratory system, 15.6%; diseases of the circulatory system, 9.6%; accidents, poisoning and violence, 7.2%. The corresponding national percentages were 17.1, 15.1, 9.2, and 7.4, respectively. The distribution in Michigan closely parallels the national distribution by diagnostic class.

Reasons for seeking care were described as a "follow-up" or "progress visit," without being expressed in terms of a symptom or problem, for 14.2% of all Michigan visits and 11.7% of all national visits.

Among the non-symptomatic reasons in Michigan, pregnancy examination accounted for 5.7%, physical examination for 3.9%, gynecological examination for 2.7%, and visit for medication for 2.3%. The national percentages were 4.0 for the first two and 2.0 for the last two.

For patients with symptomatic reasons in Michigan, pain and other problems of the lower extremities and colds each accounted for 3.5%; abdominal pain, 3.3%; back pain, 2.9%; cough and sore throat, each 2.8%; and pain and other problems of the upper extremities, 2.5%.

The corresponding national percentages were 4.0, 2.1, 2.5, 2.9, 2.8, 3.2, and 2.9 respectively. Thus, the Michigan and national distributions of patient visits with respect to the most common reasons for seeking care are similar.

For about half of the patients, the physician considered the problem not to be serious (48.6% for Michigan, 50.5 nationally). About 33% were slightly serious, and 18.6% were either serious or very serious in Michigan. Nationally, these two percentages were 30.4 and 19.2.

MSMS NOTE: Laboratory tests or procedures were performed significantly more in Michigan (7.7%) than generally throughout the U.S. One possible explanation for this could be the malpractice climate that exists in the state today.

Percent distribution of office visits by patient sex, color, and age, according to physician specialty and type of practice: Michigan, May 1973-April 1974

Physician specialty and type of practice	Total	Sex		Color		Age				
		Male	Female	White	All Other	Under 15 years	15-24 years	25-44 years	45-64 years	65 years and over
						Percent distribution				
All specialties	100.0	38.5	61.5	91.4	8.6*	19.9	18.0	26.2	22.7	13.2
General/family practice	100.0	40.4	59.6	95.3	4.7*	19.5	19.7	25.5	21.9	13.4
Medical specialties	100.0	40.8	59.2	84.4	15.6*	34.4*	7.0*	13.7*	26.5	18.4
Internal medicine	100.0	38.9	61.1	73.4	26.6*	2.4*	5.5	19.4	41.0	31.7
Pediatrics	100.0	42.4	57.6	98.5	1.5*	88.1	6.4*	3.3*	1.5*	0.7*
Other	100.0	42.9	67.1	84.7	15.3*	2.9*	13.1*	21.3*	42.7	20.0*
Surgical specialties	100.0	32.0	68.0	87.5	12.5*	12.5*	22.5	33.6	21.2	10.2
General surgery	100.0	43.9	56.1	84.4	15.6*	8.1*	17.7	29.6	29.4	15.2
Obstetrics and gynecology	100.0	4.9*	95.1	85.3	14.7*	5.8*	36.0	45.6	11.0	1.6*
Other	100.0	47.0	53.0	94.2	5.8*	26.1*	13.5	25.5	21.7	13.2*
Other specialties	100.0	46.9	53.1	97.9	2.1*	2.7*	17.3*	49.5	27.0*	3.5*
Psychiatry	100.0	46.5	53.5	97.9	2.1*	2.8*	18.0*	51.2	26.5*	1.5*
Other	100.0	53.3	41.7	100.0	0.0	0.0	0.0	0.0	41.7	58.3
Type of practice										
Solo	100.0	40.4	59.6	93.2	6.8*	16.3	15.0	26.5	25.9	16.3
Other[1]	100.0	36.1	63.9	89.0	11.0*	24.6	21.7	25.7	18.7	9.3*

[1] Includes partnership and group practices

*Relative standard error greater than 20 percent.

maximum number of subscribers, thereby accumulating the maximum number of premium dollars to achieve our ultimate objective.

I would like to urge that this viewpoint be seriously considered by the Board of Directors.

Yours sincerely,
Sidney D. Kobernick, M.D.

(Editor's note: Though initially the MPMLC will offer only $100,000/300,000 coverage, it anticipates increasing coverage in the future. The insurance bureau has said that permission to issue $200,000/$600,000 coverage will depend on reinsurance arrangements and/or increasing capitalization. As more doctors join the company, capital assets will climb. The AMA is creating a reinsurance company to back up state societies' captive companies, and the MPMLC has applied to be among those reinsured.)

LETTERS

"... I would offer the maximum coverage to attract the maximum number of subscribers ..."

I have been a firm supporter of the establishment of the Michigan Physicians Mutual Liability Company since the inception of the idea. I believe we have a unique opportunity with this company to take the kind of actions that really deter lawyers from the nuisance suit activity. I agree with the observation that lawyers who make nuisance suits derive their income from the "small" settlements they receive from insurance companies. I believe this is the area we must attack by fighting the claims to the extent that this source of income will be cut off.

With the above in mind, pursuing the course of litigation is expensive, and the company will have to possess sufficient funds to do this. The only source of such funds is the premium dollar. It is therefore understandable that premiums charged by our company cannot be substantially lower than those of existing companies until we have won our battle.

In order to obtain enough subscribers it will be necessary to provide the kind of coverage that will attract them. The present policy of our company to provide only $100,000/$300,000 coverage, while umbrella carriers cover $200,000/$600,000, is a significant dilemma for those like ourselves who wish to transfer our insurance from Medical Protective.

The dilemma resides in the fact that we are uncertain about the future of the company itself and are unwilling to give up our current coverage, while on the other hand realizing that if we do not subscribe to the company we may be contributing to its failure. If a substantial number of physicians in the state are withholding their subscription to our company on these grounds, we will not accumulate the necessary premium dollars to accomplish our ultimate objectives.

I think we must recognize that there is a risk involved with any decision we make. The question is would the risk be any greater if we were to offer $200,000/$600,000 coverage, thereby attracting more subscribers to our basic fund than by deterring subscribers with our present coverage level. It seems to me that if I were going to take a risk any way, I would go all the way and offer the maximum coverage to attract the

"... I am interested in allergic reactions to chocolate ..."

I am interested in finding the incidence of allergic reactions to chocolate because of a recent query I received from a chocolate manufacturer.

I would appreciate hearing from physicians the estimated number of their patients allergic to chocolate, and the symptoms produced. I would also appreciate receiving specific case reports, results of laboratory tests, and any other comments on the subject.

Thank you very much.

Sincerely
Claude A. Frazier, M.D.
Doctors Park-Building 4
Asheville, NC 28801

"... minor point ..."

Minor point, I suppose, but does a professional journal have to contain a cartoon like the one on page 11 of June 76 issue of *Michigan Medicine*? I, for one, object.

Thomas Coles Jr., MD
Grosse Pointe

Doctor Prophater commended

Robert C. Prophater, MD, active MSMS leader for many years, has retired from his MSMS positions "for medical and personal reasons."

On his retirement in May, Doctor Prophater was vice chairman of the MSMS Council, chairman of the MSMS Peer Review Committee, member of the MDPAC board of directors and alternate MSMS delegate to the AMA.

"You have been a real help to MSMS and to me personally, in so many capacities that your presence will be sorely missed," wrote Ernest P. Griffin Jr., MD, MSMS Council chairman, to Doctor Prophater. "We are all aware of your dedication ... to the medical profession in many, many different positions of responsibility. You have made an outstanding contribution to the Michigan State Medical Society and to the medical profession as a whole."

HEARTBEAT

William Birch, MD, former Kalamazoo physician now living in Florida, was presented an honorary doctorate at Western Michigan University's recent commencement in recognition for his untiring efforts in founding and establishing the WMU physicians' assistant program.

* * *

Ofelia J. Centeno, MD and Aaron Lupovitch, MD, both of Detroit, published an article in the June 7, 1976 Journal of the American Medical Association entitled "Postpartum Assessment of Maternal-Fetal Incompatibility" in which they explain the use of a programmable calculator to help interpret clinical laboratory data to the physician ordering the tests.

* * *

George Dellaportas, MD, Lansing, left his post as Ingham County Public Health Director effective June 1 to accept a position as director of a multi-county public health system in Texas. Doctor Dellaportas had succeeded Maurice Reizen, MD, now director, Michigan Department of Public Health.

* * *

Reed O. Dingman, MD, Ann Arbor, is new president of the Plastic Surgery Association of the Americas. North, South and Central American surgeons make up the group.

* * *

Joseph C. Denniston, MD, director of Oakdale Center at Lapeer since 1974, has resigned the post for health reasons. He is replaced by David A. Ethridge, PhD.

* * *

Donald R. Elzinga, MD, is one of two Marquette residents to receive Northern Michigan University's 1976 "President's Award for Distinguished Citizenship." The award was established to publicly recognize individuals who have supported civic, social and cultural activities. Doctor Elzinga, an orthopedic surgeon, is a Marquette native.

* * *

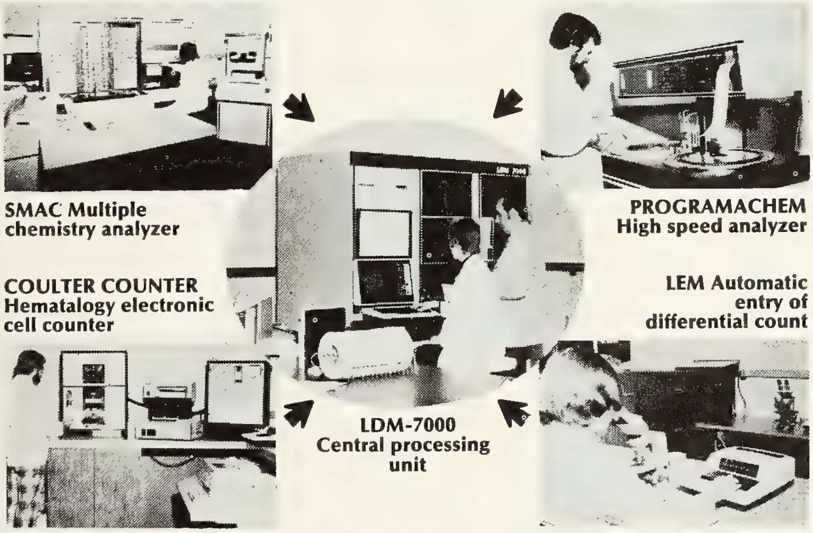
Tommy N. Evans, MD, professor and chairman of gynecology and obstetrics at the Wayne State University School of Medicine, is serving as president of the 18,000 member-American College of Obstetricians and Gynecologists. ACOG is the largest national specialty in North America.

* * *

W. H. Huron, MD and D. R. Smith, MD, are recently-named Citizens of the Year of the Iron Mountain Lions Club.

* * *

(continued on page 469)



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Progress Report

Michigan PSRO Support Center
East Lansing

• *Newly appointed associate project director* Donald P. Potter began his assignment at the Center on June 1. Terry Dwyer, former Associate Director, resigned to accept a position as Executive Director, PSRO of Central New York, Inc. in Syracuse.

Mr. Potter attended the University of Michigan Graduate School of Public Health and earned a degree of Master of Health Services Administration in May, 1976. His previous experience in association and hospital work will enable the Center to continue providing informational and technical assistance to PSROs without interruption.

• *The center's contract* has been extended through September 30, 1977 to serve Michigan's unfunded areas, while continuing to provide assistance and consultation services to planning and conditional PSROs.

• *Six additional areas* in Michigan will receive funding by the end of this calendar year according to an announcement by a representative of the Bureau of Quality Assurance. This information was learned during a meeting arranged by the Center between chairmen and/or representatives of the unfunded areas and officials from BQA and Chicago Region V. A memorandum will be mailed to each member of these six physician steering groups when the draft Request for Proposal (RFP) is received at the Center for analysis.

• *The Upper Peninsula Quality Assurance Association* (Area I) elected its first official Board of Directors. UPQAA had requested the Center to handle the arrangements for and conduct the election of 21 members by secret, mailed ballot to achieve the greatest possible participation by the membership. UPQAA deserves congratulations for the 63% of the members who responded by voting in this election.

• *What is the role of the physician reviewer* of health care services in an institution if the reviewer has any financial interest? This matter is under consideration by BQA as a result of our letter and others requesting BQA's interpretation of Section 1155(a)(6)(B) of the Social Security Act. The PSRO Manual, Section 520.04(e) defines a financial interest as follows:

"(2) A direct or indirect financial interest exists where the physician or a member of his family stands to gain or lose monetarily or in equity from the financial performance of a profit or non-profit making institution, organization or agency which provides health care services . . . "

The Bureau is developing a policy that "would consider a financial interest to be an ownership interest in the institution, and include the following: sole ownership interest in the institution, a partnership interest in the institution, any direct stock ownership or debt interest which is convertible to stock or which is secured by stock in the institution, or a controlling interest in an organization which holds any ownership interest in the institution. Under this latter definition of financial interest, an equity interest, such as revenue bonds, would not be a financial interest for purposes of Section 1155(a)(6)(B), since equity interests are not ownership interests."

• *Briefs:* The establishment of the first six Statewide Professional Standards Review Councils is scheduled for contracts early in the new fiscal year (September 30). Michigan will be eligible to contract for an SPSRC when a third conditional PSRO is designated possibly by the end of this calendar year.

Terms of all 11 members of the National Professional Standards Review Council will expire on June 30. Nearly 100 groups submitted nominations for HEW's consideration. While some of the current members will be reappointed, the expected 5 vacancies generated intense competition for seats on the Council. It is expected that the appointments will be made before June 30 in time for the new group to meet as a new Council tentatively scheduled the second week of July.

• *Future workshop topics* suggested by the attendees at the April 28 Workshop on "Medical Care Evaluation Studies — Design, Conduct, Analysis, Change" rated their preference in the following order: (1) Legal Issues Concerning PSRO Operations, (2) Allied Health Involvement in the PSRO System, and (3) Data Processing.

Larry E. Jennings, MD, Jackson family physician, is the recipient of a resolution of appreciation by the Jackson County Board of Commissioners for his services in establishing a health program in the county's youth center and in voluntarily providing medical care to the wards of the court housed there.

* * *

Elliot D. Luby, MD, Detroit, is chairman of a new Program for Alcohol Studies recently approved by the Wayne State University Board of Governors.

* * *

Marjorie Peebles-Meyers, MD, and Marie A. Petrini, MD, both of Detroit, are recipients of Distinguished Alumni Service Awards presented at recent WSU Medical Alumni Day activities. Doctor Peebles-Meyers, the first black woman to serve an internship and residency at Detroit General Hospital, is a senior attending physician in the department of medicine at Hutzel Hospital and is a clinical associate professor of internal medicine at WSU. Dr. Petrini is a recognized authority on human sexuality and is a clinical associate professor of gynecology and obstetrics at WSU.

* * *

Richard D. Remington, PhD, dean and professor of public health at the University of Michigan School of Public Health, Ann Arbor, is a new member of the Board of Trustees of the Commission on Professional and Hospital Activities (CPHA). Michigan doctors serving on the board are Darrell A. Campbell, MD, Ann Arbor, and Vergil N. Slee, MD, Ann Arbor, who was re-elected president of the organization.

* * *

Alfred B. Swanson, MD, Grand Rapids, was guest lecturer at two recent national meetings of hand surgeons. In Philadelphia he presented a lecture on "Flexible Implant Arthroplasty of the Hand and Wrist, Rehabilitation Aspects." While at Johns Hopkins University in Baltimore he presented lectures on advances in implant arthroplasty of the elbow, wrist and hand and classification of congenital limb malformations.

* * *

C. Howard Ross, MD, Ann Arbor, is a recent recipient of the Ann Arbor Exchange Club's 1976 "Book of Golden Deeds" award for community service. An active "85 years young," Doctor Ross was a teacher, botanist, forester and manufacturer prior to becoming a physician. He practiced in Ann Arbor from 1932 until his retirement in 1968. He has served on various committees of MSMS and remains active in Washtenaw County Society activities as well as in the American Geriatrics Society.

* * *

W. L. Berridge, Jr., MD, Warren, is new president of the Michigan Industrial Medical Association for 1976-77. Henry C. Scharweber, MD, Midland, was named president-elect; William L. Knapp, Flint, was elected vice-president and Denis F. Cash, MD, Detroit, secretary-treasurer. Installation and elections took place at Bay Valley Inn on June 3-4.

American College of Chest Physicians

POST GRADUATE COURSE

Acute Respiratory Failure

MECHANISMS AND MANAGEMENT

Ann Arbor, Michigan
September 29-October 2, 1976

Co-Sponsored by
the American College of Chest
Physicians and the University of
Michigan Medical School

Location:
University of Michigan Medical School
Ann Arbor, Michigan

Course Director:
John G. Weg, M.D.

Associate Director
James T. Stringfield, M.D.

Credit:
28 hours credit toward the American Medical Association Physician's Recognition Award under Category 1.

COURSE DESCRIPTION:
This course will provide a comprehensive update of the basic pathophysiologic mechanisms of acute respiratory failure. As a foundation for intelligent management, it will provide practical information on the bedside utilization of newer cardiopulmonary monitoring techniques essential for the care of the critically ill. It will review catastrophes — pulmonary emboli, septic shock, barotrauma, etc., which commonly complicate respiratory failure.
Respiratory Intensive Care Unit rounds will be televised live each day with audience participation; small group problem solving, workshops, independent study units and 'Meet-the-Professor' sessions will assure active attendee participation.

- Mechanisms of Hypoxemia
- Acute Respiratory Failure in Chronic Obstructive Pulmonary Disease: Diagnosis and Conservative Therapy
  Reuben M. Cherniack, M.D.
- Mechanisms of Pulmonary Edema Formation
- Mechanisms of Pulmonary Hypertension
  Norman C. Staub, M.D.
- Pulmonary Emboli
- The Preoperative Evaluation of Patients
  Myron Stein, M.D.
- **For further information contact:**

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CHEST PHYSICIANS
Department of Continuing Education
911 Busse Highway,
Park Ridge, Illinois 60068

MEETINGS

(See also listing of Category I programs on page 459)

August 8-13 — Short Course, "Problems in Planning and Evaluation," sponsored by University of Michigan School of Public Health at Campus Inn Hotel, Ann Arbor, contact: Dr. Anna B. Brown, University of Michigan, 109 S. Observatory Street, Ann Arbor 48109

September 1 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director.

Sept 1-3 — Annual fall meeting, Michigan Health Officers Association, Grand Hotel, Mackinac Island, contact: James M. Davis, MD, Van Buren County Health Department, Box 307, Hartford, 49057.

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September 2-15 — MSMS/INTRAV trip, Western European Air/Sea Cruise, contact: Marcelyn Ireland, MSMS Headquarters.

September 14 — 6th Annual Michigan Heart Association Cardiovascular Research Forum at University of Michigan Medical Science Building, Ann Arbor, contact: Michigan Heart Association, P.O. Box LU-160, Southfield 48076

September 15 — Annual Muskegon Trauma Day, Holiday Inn, Muskegon, contact: G. W. Annessa, MD, 1470 Peck St., Muskegon 49441

September 18 — September Seminar, "Lesions of the Bone," Michigan Society of Pathologists, St. John Hospital, Detroit, contact: Robert Hendrix, MD, Dept. of Pathology, University of Michigan, Ann Arbor 48109

September 27-Oct. 12 — MSMS/INTRAV trip, Singapore-Bali-Hong Kong Adventure, contact: Marcelyn Ireland, MSMS Headquarters.

September 29-Oct. 2 — Conference, Chest Physical Therapy, sponsored by American College of Chest Physicians at Dow Auditorium, Towsley Center, contact: Janet Johnson, Room G2115, Towsley Center, University of Michigan Medical Center, Ann Arbor 48109

October 1-3 — Michigan Regional Meeting, American College of Physicians, at Otsego Ski Club, Gaylord, contact: Beverly C. Payne, MD, FACP, 425 E. Washington St., Ann Arbor 48108

October 6-9 — Convention, American Medical Writers Association, Pontchartrain Hotel, Detroit, contact: Lillian Sablack, executive director, AMWA, 9650 Rockville Plaza, Bethesda, MD 20014

October 20 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director.

October 29-30 — 1976 State Conference of Michigan Association for Children with Learning Disabilities, at Hyatt Regency, Dearborn, contact: Bea Bury, 2876 Munsfield Ct., Bloomfield Hills 48013

November 6-7 — Conference, "Mind as Healer/Mind as Slayer," sponsored by University of Michigan Extension Service and the Institute of Noetic Sciences in Dearborn, MI, contact: Maurice J. Cameron, 3500 South Thayer, Ann Arbor 48104

December 11 — December Seminar, "Lesions of Salivary Glands," Michigan Society of Pathologists at Rackham Auditorium, University of Michigan, Ann Arbor, contact: Dr. John Dunkel, MSU, Department of Pathology, Fee Hall, Room 677, E. Lansing 48824.

December 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director.

"That was the interior designer. He says you'll have to go!"

in memoriam

Ildefonso Arenas, MD
West Bloomfield

Radiologist Ildefonso Arenas, MD, West Bloomfield, died June 3 at the age of 42. Doctor Arenas received his medical degree from the University of Madrid and had been in the U.S. five years. He was treasurer of the Michigan Society of Therapeutic Radiologists, a member of the American Society of Therapeutic Radiologists and the American College of Radiology. He was affiliated with Harper Hospital.

Frederick M. Boothby, MD
Lawrence

Lawrence family physician Frederick Martin Boothby, MD, died May 31 at the age of 74. Doctor Boothby was a graduate of Loma Linda University's medical school and had served his community since 1931. He was instrumental in founding Lake View Community and Watervliet Community hospitals and was honored with the naming of "Dr. Fred Boothby Day" by his community in 1970. He was past president and a former delegate of the Van Buren County Medical Society.

Sylvan A. Broadman, MD
Farmington

Pediatrician Sylvan A. Broadman, MD, Farmington, died June 15 at the age of 61. Doctor Broadman received his medical degree from New York University and served four years with the Army Medical Corps in the Pacific. He practiced for 20 years with the Gariepy Medical Clinic in Detroit before opening his own practice in Farmington. He was on the staffs of Children's and Mt. Carmel Mercy hospitals and had been affiliated with Highland Park General. He was past president of the Detroit Pediatrics Society and a member of the Wayne County Medical Society.

Earl H. Engel, MD
Wyandotte

Wyandotte physician Earl H. Engel, MD, died June 5 at the age of 75. A graduate of the University of Nebraska College of Medicine, Doctor Engel was a former chief of staff of Wyandotte General Hospital. He was former director of the Wyandotte Health Department and served 10 years with the Wayne County Board of Health. On his retirement as medical director of Wyandotte Public Schools in 1974, his city designated "Dr. Earl H. Engel Day." He was a member of the Wayne County Medical Society.

Harold C. Hill, MD
Howell

Family physician Harold C. Hill, MD, Howell, died April 19 at the age of 69. Doctor Hill, a life-long resident of Livingston County, earned his medical degree from the University of Michigan Medical School. He was affiliated with McPherson Community Hospital and practiced in Howell for over 40 years. He was a fellow of the American Academy of Family Physicians, and past-president and former delegate of the Livingston County Medical Society.

Gordon S. McAlpine, MD
Birmingham

Internist Gordon S. McAlpine, MD, Birmingham, died June 5 at the age of 86. Doctor McAlpine was a graduate of the University of Toronto and interned at Harper Hospital in Detroit. Before his retirement in 1967, he had practiced medicine in Detroit for 50 years.

Frank F. Pray, MD
Fenwick

Family physician Frank F. Pray, MD, formerly of Jackson, died June 9 at the age of 91. Doctor Pray was graduated from the University of Michigan Medical School and, until his retirement in 1967, actively practiced medicine for 52 years. He was affiliated with the W. A. Foote Hospital in Jackson.

Peter B. Rastello, MD
Sun City, AZ

Industrial medicine specialist Peter B. Rastello, MD, formerly of Orchard Lake, died June 15 at the age of 79. Doctor Rastello was a graduate of the University of Michigan Medical School and was affiliated with Harper Hospital in Detroit. He had been the medical director for General Motors Corporation for 35 years. Doctor Rastello was former chairman of the MSMS Section on Occupational Medicine. He also held office as the president of the Michigan Industrial Medical Association.

Elmer W. Schnoor, MD
Grand Rapids

A surgeon for more than 50 years, Elmer W. Schnoor, MD, Grand Rapids, died June 4 at the age of 86. Doctor Schnoor received his medical degree from Northwestern Medical School. He taught surgery at the University of Illinois, then came to Grand Rapids where he served on the staffs of Butterworth, Blodgett, and St. Mary's hospitals. Doctor Schnoor was past president of the Kent County Medical Society. He was a member of the American College of Surgeons and also held office as the president of the federal and state Boards of Medicine.

CLASSIFIED ADVERTISING

NEEDED: Internist, full-time, for review of Social Security disability applicant files at our Lansing, Oak Park and Traverse City offices. Good salary, good fringe benefits, no malpractice insurance required. Deferred compensation available. Inquiries answered confidentially, an equal opportunity employer. Call collect (517) 373-7789 OR Write: Michigan Department of Education, Vocational Rehabilitation Services, Disability Determination Program, Box 1200, Lansing, Michigan 48904, Attention: David P. Gage, M.D., Chief Medical Consultant.

WANTED: Staff Physician with or eligible for Michigan License for 350 bed fully accredited hospital for the care of rehabilitation, tuberculosis, psychiatric and chronic disease patients. 40 hours week. Excellent salary and fringe benefits. Reply: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, Michigan 48605.

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For additional information contact: Personnel Department, Oakland County Courthouse, 1200 N. Telegraph, Pontiac, Michigan 48053. Telephone: (313) 858-0535.

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The community is rural, with a population of approximately 3,000, and a service area of 8-10,000, located 120 miles Southwest of Minneapolis. It has a diversified economic base, underpinned by some of the country's most productive agricultural land. It has a broad range of religious, service and social organizations.

The community currently has three general practitioners, one of whom is semi-retired, averaging 60 years of age. It has two clinics, a 34-bed hospital, a 60-bed nursing home and two pharmacies.

A surgeon and pathologists from Mankato and a radiologist from Albert Lea make regular trips to the community and hospital. Medical specialists are available at Mankato (35 miles) and Albert Lea (25 miles).

For additional information, contact D. H. Gilbert, Wells Municipal Hospital, 400 - 4th Avenue, S.W., Wells, Minnesota 56097. (507) 553-3111 or 553-5904.

ALLERGIST: Dermatology Service — VA Hospital, Allen Park, Michigan. Part-time vacancy (20 hours per week) in active, well equipped allergy clinic in GM&S hospital. Progressive program of continuing education; affiliated with Wayne State University. Salary commensurate with advanced preparation, number years of practice and attainment of recognized professional stature in medicine. In addition, we offer excellent retirement plan, liberal laws leave policy and health and life insurance programs. Contact Dr. Savoy, (313) 562-6000, Extension 698. An equal opportunity employer.

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POTPOURRI

By Herbert A. Auer, Executive Editor

"Be sure to visit Detroit in 1976" is the appeal this year of the Detroit Convention and Visitors Bureau. And MSMS agrees — urging doctors and their spouses to participate in the 1976 MSMS Annual Scientific Session at the Hyatt Regency Hotel in Dearborn Nov. 9-10-11. See you in Detroit this fall!

* * *

True or False? Some people probably ask their pharmacist for the cheapest generic drug . . . but then cross the aisles to buy the top-line scotch.

* * *

The Michigan Department of Management and Budget is predicting that by 1980, the K-12 enrollment in Michigan schools will be about 12 percent below the 1971-72 record high of 2,212,523. The era of unprecedented growth of Michigan public school enrollment is over. During the 1950s and 1960s, the number of pupils grew an average of 50,000 each year and enrollment doubled from one million to more than two million pupils. The decline was caused by a dramatic drop in the number of births. The largest number of births in Michigan occurred in 1957 with 208,488. Except for 1969 and 1970 there has been a steady drop in births to a new low of 137,285 or 34 percent below the 1957 level. The decline in births is expected by state officials to bottom out next year.

* * *

Lest we take the platforms of the National GOP and Democratic Party Conventions too seriously, remember that Wendell Wilkie once called the platforms "fusions of ambiguity."

* * *

The authors of Random House, Webster Dictionaries, etc., declare that the word "viable" is overworked and misused. As in other fields, health care speakers could more sharply use the word "valid" in place of "viable" because there are shades of difference.

* * *

Columbia University researchers report that women today are fatter than 15 years ago and obesity is still on the rise despite the $10 million that Americans spent last year on diet and exercise paraphernalia. Despite peer-group pressure that "thin is in" both men and women weigh more — with women weighing more proportionately than men.

* * *

The views of Yale Professor William Sumner continue to pop up — most recently in a special magazine supplement of *The National Observer*. Known best for his essay, "The Absurd Effort to Make the World Over," Sumner contended that "the sentimentalists have filled the minds of ignorant men with impossible dreams." The attempt to make the world over would surely lead to the "survival of the unfittest," he declared.

* * *

Newspaper advertisers watch demographic trends so the Newspaper Advertising Bureau carefully studies population shifts. NAB predicts large growth in the next 10 years in two segments — the 25 to 44 age group and households with incomes over $25,000. The total number of households will jump from 72 million now to 89 million by 1985.

* * *

"A strong weapon against corruption and moral decay is an economy in which the only route to success is superior performance in open and competitive markets," declares Paul W. McCracken, University of Michigan economist, in a series of magazine advertisements being run by United States Steel. The theme for the advertising messages is "What makes America work? — An economy free from wage and price controls."

* * *

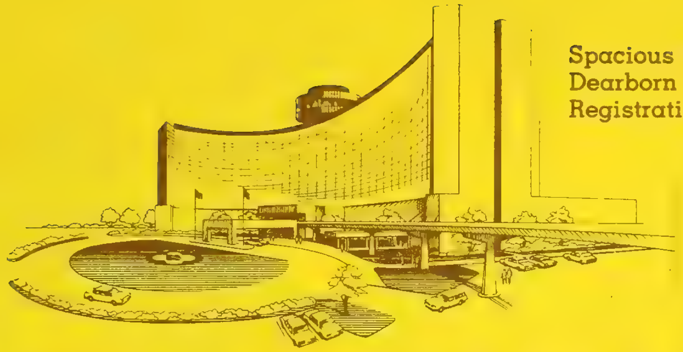
The *American Medical News* carried a recent editorial with the heading, "Welcome to the Future." The article posed a series of statements that "something ought to be done" about liability insurance, about health legislation, etc. In part, the editorial stated:

"Something ought to be done about involving more physicians in organized medicine. The men and women who practice medicine have a national organization that is their voice, that speaks to the best interests of public and patient, and that offers every physician representation in its own deliberations. What it needs is more members."

That organization, I am sure you guessed, is the American Medical Association — and the Michigan State Medical Society — and the component societies in Michigan and across the nation.

* * *

The possibilities of a PAC (like our MDPAC) is being advocated by James Barrett, new executive of the Michigan State Chamber of Commerce. The suggestion to step up business efforts to influence governmental decision-making is accompanied by C. of C. reports that labor contributed $155,000 in 1974 to State House races, with $154,000 going to Democratic candidates.



Spacious Hyatt Regency in
Dearborn awaits doctors, spouses.
Registration form inside back cover.

MICHIGAN MEDICINE

ICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 9 SEPTEMBER 1976

REGISTER TODAY
FOR COURSES, EARN
CATEGORY I CREDIT

NEW HYATT
REGENCY,
DEARBORN

SOON,
NOVEMBER
9-10-11

MSMS Scientific Meeting

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Glide up in glass-enclosed elevators at Hyatt Regency, in Dearborn, to all 18 floors of bronze-colored elegant new hotel. And ride the monorail to 110 stores in the Fairlane Shopping Center. MSMS meeting rooms will be on first two floors with spacious guest rooms starting on the third floor. The $40 million Hyatt Regency is handy off the expressways with acres of parking. A truly great hotel. Ideal for the 1976 MSMS Annual Scientific Meeting, Nov. 9-10-11.

MSMS members and spouses are invited to spend several days at spacious Hyatt Regency in Dearborn. Earn credits. Have fun. Reservation on inside back cover.

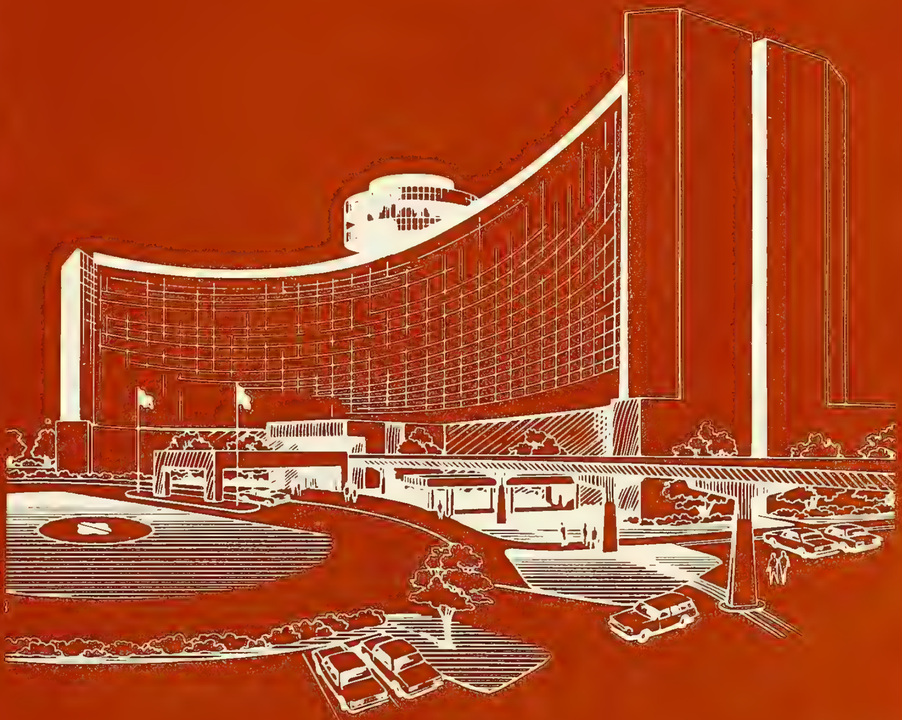
Read Medigram for details about 44 half-day Category I Courses to be offered Nov. 9-10-11 by specialty societies, MSMS sections and MSMS Committee on CME Programming at the MSMS Annual Scientific Meeting.

MICHIGAN MEDICINE

FFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 9 SEPTEMBER 1976

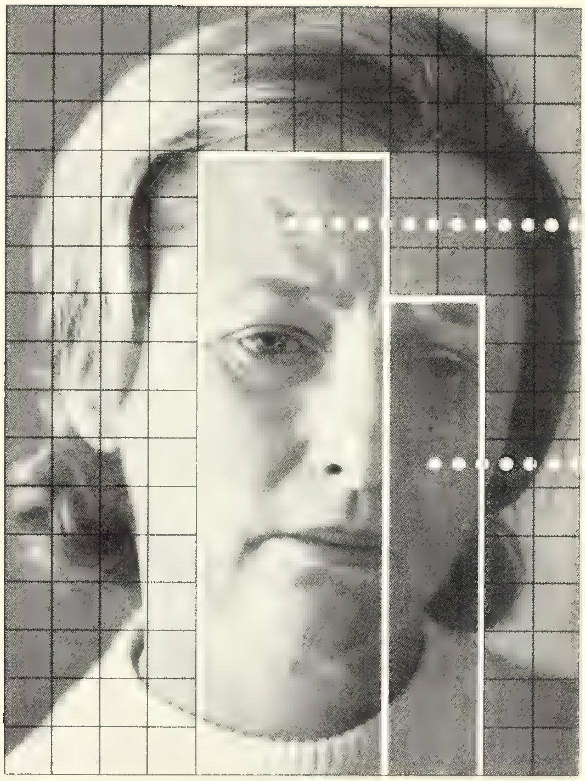
Robert F. Wilson, MD, is general chairman for ambitious 1976 MSMS Annual Scientific Meeting

Hyatt Regency Dearborn



Spacious Hyatt Regency in Dearborn awaits Michigan doctors, spouses Nov. 9-10-11. Learn . . . And enjoy a fall vacation!

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

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2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue

The possible human health hazards of polybrominated biphenyl (PBB) will be discussed in the October issue of *Michigan Medicine*. Experts from science and medicine will offer their views. The question has been in the news since PBB was accidentally mixed into Michigan animal feed several years ago and found its way through the food chain to humans. Included in the *Michigan Medicine* articles will be excerpts from the findings of the Governor's Scientific Advisory Panel on PBB and the Michigan Senate Special Investigating Committee on PBB.

Watch for these important articles.

Michigan Medicine, Volume 75, Number 9, September 1976

One of the finest opportunities for Michigan physicians to earn their Category I continuing medical education credits is coming soon in the 1976 MSMS Scientific Meeting Nov. 9-11 at the Hyatt Regency Dearborn. Program and meeting plans are included in this issue, pages 482-486. Don't miss them.

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

A 'truly great program' scheduled Nov. 9-11 for MSMS Scientific Meeting in Dearborn

Ernest P. Griffin, Jr., MD
Chairman, MSMS Council

(MSMS President Robert M. Leitch, MD, has invited Doctor Griffin to present the following guest column this month.)

Personally I want to appeal to you to participate in the 1976 MSMS Annual Scientific Meeting at the Hyatt Regency Hotel in Dearborn. As Council chairman, I have had the opportunity to see the meeting develop and to personally know the project leaders.

A truly great program awaits you in November.

Now our members must cooperate by registering in advance for the courses so the right rooms can be assigned, so materials can be duplicated, and so the registration and credit-verification procedures can be developed.

The MSMS Council appreciates the excellent cooperation being given by the many specialty societies. They are enthusiastic about the opportunity to present half-day courses, which will go into considerable depth on one subject or present an overview of many closely related topics. Many of these specialty societies have changed some of their old traditions in order to offer courses and in order to participate in some different approaches to meal functions and other details.

I know that many hours of work have already gone into the planning, with more hours being spent now to complete course outlines, syllabuses and self-examination questions.

The doctors of Michigan owe a great deal to Doctor John G. Wiegenstein, Programming Committee chairman; and to Doctor Robert F. Wilson, the Annual Scientific Meeting chairman, and his assistants and to the many physicians who will serve as instructors for the courses.

This new academic, scholarly, orderly approach to the Annual Session is necessary so MSMS can meet the standards and criteria of the AMA and the State Medical Practice Board so the courses can carry Category I credits towards recertification here in Michigan.

Michigan is the only state with a 50-hour requirement in effect with a one-year deadline and that creates real pressure here for all our doctors. Michigan doctors, in order to get their licenses renewed for 1977, must obtain at least 25 hours of Category I credits by Nov. 30.

We hope that this 1976 meeting in early November will help the doctors who may have procrastinated unknowingly or who may be short some of the required hours.

The CME programming planners assure me that a quality program has been arranged, dealing with vital topics to help the physician in his everyday practice.

(Continued on page 485)

When impotence due to
androgenic deficiency
is driving them apart
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Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** * **Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Inositol	10 mg
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Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
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ACTION AND USES DOSAGE: 1 tablet after breakfast and supper or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets.

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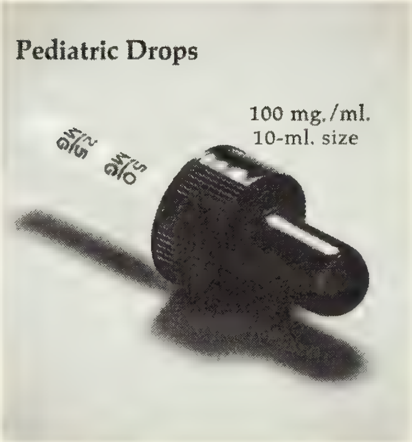

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How you benefit as an MSMS member

–By being able to participate in the top-quality MSMS-sponsored educational programs.

MSMS provides its members with several excellent opportunities each year to improve their medical knowledge and skills. The MSMS scientific offerings also give Michigan physicians the chance to earn required continuing medical education credits, as all MSMS programs are approved for Category I status.

The major MSMS programs offered annually include the Maternal and Perinatal Health Conference, the Conference on the Medical Aspects of Organized Athletics, both in the spring, and the Scientific Meeting.

The coming 1976 Scientific Meeting is scheduled Nov. 9-11 at the exciting Hyatt Regency Hotel, Dearborn, and will provide Michigan physicians the opportunity to earn all 25 required Category I CME credits during its three-day run. (Please see additional articles on pages 482-486).

Organizing these three major meetings (the Maternal Health Conference is a two-day event, the Medicine and Athletics Conference a one-day event) is the new MSMS Committee on CME Programming, chaired by John G. Wiegenstein, MD, Lansing, founding president, American College of Emergency Physicians.

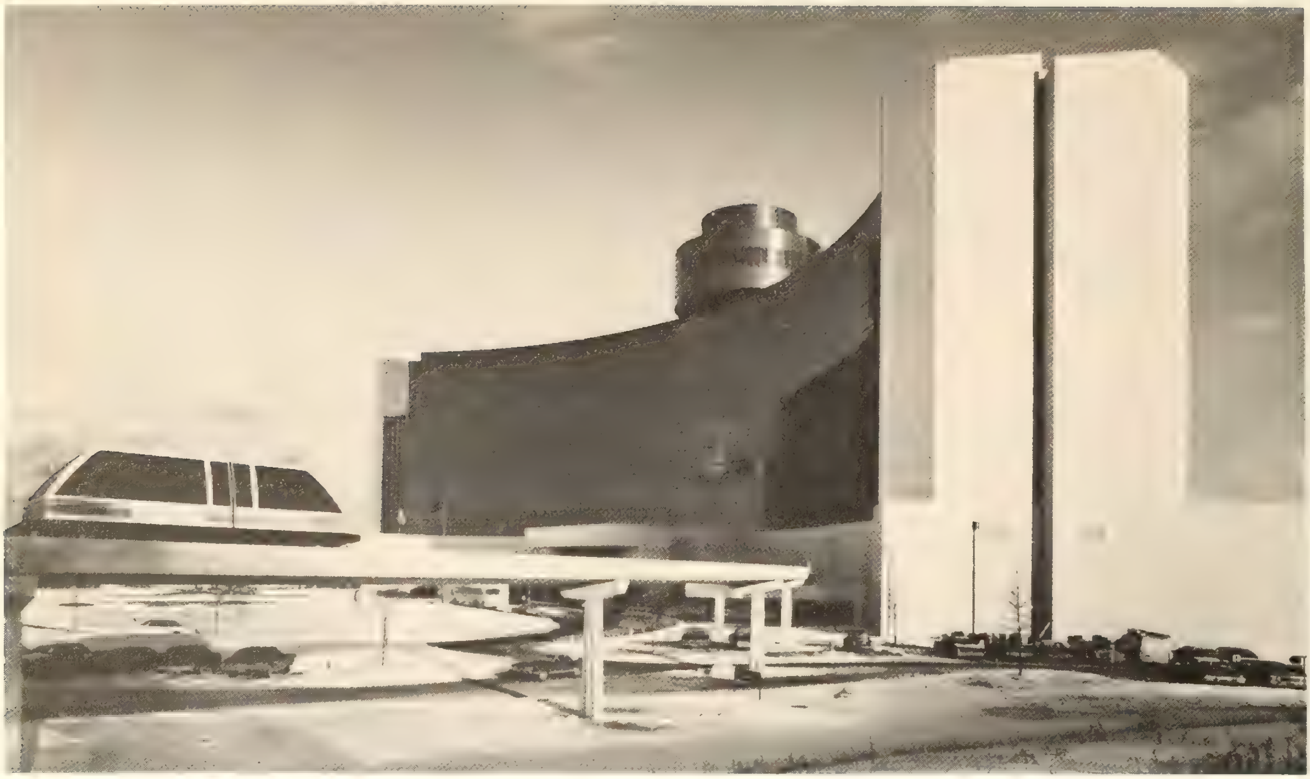
The committee has 12 MD-members, representing private practice and the state's medical schools, seven top-notch consultants and MSMS staff manager Herbert Auer, continuing education expert. The committee has earned approval to present Category I programs from the MSMS Commission on CME.

The purpose of the committee is to strive to make available continuing medical education to all MSMS members, and thus enhance patient care. It was established in March, 1976, by the MSMS Council to function in one of the major areas selected by MSMS for emphasis during 1976.

The committee also is responsible for selected CME activities in which MSMS experts and resources can make contributions; and to provide general coordination, counsel and cooperation with other CME sponsors in Michigan. It is developing plans to conduct a random survey of physicians to determine their needs and interests.

In addition to the three major courses described above, available to MSMS members at minimal fees, MSMS co-sponsors and helps present other CME courses in Michigan throughout the year.

MSMS is working to establish more opportunities for physicians all around the state to attend more good CME courses, and to continually upgrade and evaluate physicians' attendance and the course content of existing programs.



The Hyatt Regency Hotel, Dearborn, and monorail to shopping center.

MSMS members may choose from 36 courses at MSMS Scientific meeting

A quality program awaits Michigan physicians planning to attend the 1976 MSMS Annual Scientific Meeting Nov. 9-11 at the attractive, spacious Hyatt Regency Hotel in Dearborn.

"In order to help Michigan doctors obtain the required Category I Continuing Medical Education credits, the Tuesday-Wednesday-Thursday Annual Meeting will feature more than 30 different half-day courses," according to Robert F. Wilson, MD, Detroit, program chairman.

"It will be possible for a doctor to earn all 25 of the required Category I CME Credits at the Annual Meeting if he has not already earned some hours," stressed Doctor Wilson.

Doctor Wilson, an assistant dean of the Wayne State University School of Medicine, and well-known for the many trauma conferences he arranges across the state, was appointed general chairman by MSMS Council Chairman Ernest P. Griffin, Jr., MD, upon the recommendation of John G. Wiegenstein, MD, Lansing, chairman of the MSMS Committee for Continuing Medical Education Programming. The programming committee has been accredited to conduct this Category I activity.

The 36 half-day courses that will fill the three days will be offered by 21 cooperating, state-wide medical specialty societies and by the CME Programming Committee.

MSMS members may register for a maximum of six courses, two each day. In addition, physicians will be able to take advantage of some of the accredited independent study programs, like the University of Michigan Media Library.

In addition to course outlines that will be given to the registrants in each course, plans are being made to provide some optional testing before and after the courses.

Nov. 9-10-11 Scientific Meeting at Hyatt Regency offers 25 Category I credits

Here is an outline of the program:

Tuesday AM, Nov. 9:

—Emergency Medicine: Management of Hypertensive, Urologic, and Psychiatric Emergencies.

—Drug Problems and Interactions Associated with Sepsis; Organ Failure and Metabolic Abnormalities

—Microbiology — Classification and Diagnostic Techniques

—End-State Organ Disease: Transplantation vs Mechanical Devices

—Treatment of Common Athletic Injuries

—Arrhythmias

—Radioisotopes to Diagnose Metabolic Abnormalities

Tuesday PM, Nov. 9:

—Preventative and Public Health: Schizophrenia; and Drug Interaction and Body Response

—Infection and Metabolic Problems re Infection

—Medical/Legal Ramifications of Practice

—Non-invasive Assessment of Cardiac Performance in Coronary Artery Disease.

—Radiological Diagnosis of Infection

Wednesday AM, Nov. 10:

—Gastroenterology: Endocrine Tumors of the Foregut

—Family Practice: Neonatology

—Clinical Pharmacology and Therapeutics and Public Health: Clinical Pharmacology, Metabolism, Toxicology and Public Health Aspects of PBBs and PCPs in Michigan

Wednesday PM, Nov. 10:

—Allergy: Treatment of Allergic Asthma

—Anesthesiology: Beta Adrenergic Blockers — Pharmacology, Metabolism and Clinical Uses

—Plastic Surgery: Subcutaneous Mastectomies and Implants

—Pediatrics: Immunization for the Prevention of Acute Infectious Diseases

—Otolaryngology: Comprehensive Approach to the Dizzy Patient

—Orthopedics: (Topic to be finalized)

—Obstetrics and Gynecology: Nutritional Balance; Diet for Pregnancy; Diet for Hyperalimentation

—Internal Medicine: Diabetes Update; Proper Antibiotics for Infections

—Dermatology: Bacterial Infections of the Skin, Therapy of Cutaneous Infections in Children; Pathogenesis of Recurrent Herpes Simplex and Concepts in Therapy.

—Colon and Rectal Surgery: Septic Complications of Inflammatory Bowel Disease; Use of Pre-, Intra-, and Post-Operative Antibiotics in Colonic Surgery.

Thursday AM, Nov. 11:

—Medical Practice and Medical Education

—Hypertension

—Oncology for the Family Physician

—Therapeutic Radiology: Nutritional Management of Cancer Patients

—Current Status of Surgical Management of Carcinoma of the Colon and Rectum, Obesity, Vascular Disease, Endocrine Disorders, Portal-Hypertension, Pancreatitis, Peptic Ulcer Disease, Carcinoma of the Esophagus, Stress Gastric Bleeding, and Endoscopy

—Thoracic Surgery: Thoracic Infections, Physiology, Metabolism and Sepsis

Thursday PM, Nov. 11:

—Thoracic Surgery: Thoracic Endoscopy

—Ophthalmology: Corneal Disease

—Psychiatry: Psychiatric Aspects of Neuro-Endocrine Disease and Neuro-Endocrine Aspects of Psychiatric Disease

—Chest Physicians: Respiratory Failure, Infection of Lungs

—Surgery: Current Status of Surgical Management of — Carcinoma of Colon and Rectum, Obesity, Vascular Disease, Endocrine Disorders, Portal-Hypertension, Pancreatitis, Peptic Ulcer Disease, Carcinoma of the Esophagus, Stress Gastric Bleeding, and Endoscopy

Hyatt Regency superb setting for MSMS Scientific Meeting

The annual MSMS Scientific Meeting has never been held at such an elegant hotel — nor one that is better equipped for the many courses, meetings, exhibits, meal functions, social activities, etc.

And the adjacent Fairlane Shopping Center with 110 stores already open, with Greenfield Village, with the Dearborn Inn, etc., all add to attract doctors and their spouses to spend two or three days at the Annual Meeting, Tuesday, Wednesday, Thursday, Nov. 9, 10, 11.

The entire Fairlane complex covers 2,360 acres which give a new skyline to the city of Dearborn. This is now a far cry from the farmland where Henry Ford I was born. Ford Motor Company bought the land in 1951 from the Ford family and the project now is the "biggest chunk of metropolitan land under one ownership in the nation."

One of the unique features of the Hyatt Regency and the shopping center is the monorail that connects the two, with its speedy streamlined cars whisking back and forth all day.

The $40 million Hyatt Regency is the greatest convention hotel in Michigan. And it will remind travelers of the striking Hyatt hotels in Atlanta, Chicago, Los Angeles and other big cities. Warm, bronze-colored reflective glass helps the 18-story hotel stand out on the horizon.

As in other Hyatt hotels, the Dearborn facility features an atrium with five glass enclosed elevators that move up and down smoothly. The atrium includes more than 500 live plants and the lobby features unusual lighting art.

The MSMS registration area and Exhibition Hall will be on the first floor, along with some of the larger courses. The second floor conference suite level, easily accessible with escalators, will hold most of the MSMS courses.

The spacious guest rooms begin on the third level of the atrium. The hotel features outstanding food and beverage services in a broad array of settings — La Rotisserie, LePrelude, Kafay's Place, db's Club, the Rotunda and the LobbiBar. The Four Freshmen will be the big-name entertainers in db's Club while the MSMS meeting is underway.

Doctors and their spouses should make their own room reservations direct with the Hyatt Regency, Fairlane Town Center, Dearborn 48126.

Doctors can study individually during MSMS meeting, too

Michigan physicians will be introduced at the 1976 MSMS Annual Scientific Meeting, Nov. 9, 10, 11 to some of the growing number of independent study programs that can provide Category I opportunities.

The Michigan demonstration area, appropriately, will feature the University of Michigan Media Library, which proved popular at the 1975 annual meeting.

Physicians actually will be able to earn credits by viewing some of the programs and by taking tests.

Several of the accredited forms of self-teaching devices and programs will be available at the meeting.

The MSMS display and sample program will include the University of Michigan Media Library, the American College of Surgeons medical skills library; Wyeth teaching machines, McGraw-Hill materials re emergency medicine, and Network for Continuing Medical Education antibiotic therapy test.

Physicians are urged to experiment with these programs. Much of this material is available at the three medical schools, at some of the residency training programs, at some hospitals and clinics.

The MSMS Continuing Medical Education Programming Committee in hearty discussion with representatives of specialties at the Hyatt Regency Hotel as they plan the 1976 MSMS Scientific Meeting.

Doctor Wilson

Question:

"Why did you choose 'Sepsis and Metabolism' this year for the Annual Scientific Meeting theme, Doctor Wilson?"

Answer:

" 'What's New in Sepsis and Metabolism' is indeed a meaningful theme this year. These two topics were chosen because of the recognition that an increasing number of major medical problems are associated with septic and metabolic complications.

"These two complications are closely related; prolonged catabolic changes decrease host resistance to infection, and efforts to improve metabolism such as with hyperalimentation have helped to improve host resistance.

"Treatment of patients with various types of cancer also frequently results in septic and metabolic problems; the agents used not only reduce host resistance and increase the tendency to infection, but also have striking effects on the ability of the patient to eat and maintain proper metabolic balance.

"Most of the Annual Session courses tie into the theme so we have a program both of high quality and of real value to the participating physicians. We are striving to present a program of maximum educational quality, and also help fulfill the requirements set forth on a state and national basis for continuing medical education credits."

DOCTOR GRIFFIN/*Continued*

The theme, "What's New in Sepsis and Metabolism" is timely. There is growing recognition, I can see, that many medical problems are associated with septic and metabolic complications. With the continuing high incidence of professional liability suits in Michigan, every doctor must protect himself by keeping up to date on new developments — more so than ever before.

The MSMS Council and its Finance Committee carefully studied the proposed budget for the 1976 Annual Meeting and I am confident that every effort is being made to provide quality courses at the lowest possible charge to the doctor. The AMA charges a standard $10 per credit hour for its courses and some universities and specialty societies are charging higher fees. MSMS is certain that $5 per credit hour will be adequate to carry the project. Total MSMS investment in the Annual Session will amount to $61,000 from the dues paid by members.

The cost of sponsoring this meeting would be much, much greater if we did not have so many Michigan doctors willing to teach without any remuneration. In this case, they are our "unsung heroes."

Members of all three Michigan medical school faculties will teach at the MSMS annual session. We are especially appreciative of the heavy input this year from the Wayne State University School of Medicine.

It is appropriate, I feel, that MSMS members will be permitted to take courses for half of the cost that will be charged non-members. Non-members will be charged $10 per credit hour. The Annual Session becomes a member benefit as we cut the tuition charge in half for our members. Here is another positive example of how MSMS serves its members.

Please make every effort to participate in the quality 1976 MSMS Annual Scientific Meeting, Nov. 9, 10, 11 at the Hyatt Regency Hotel in Dearborn.

SCIENTIFIC MEETING/*Continued*

Buffet luncheon offered each day

Among the several innovations at the 1976 MSMS Annual Scientific Meeting will be a new approach to the luncheons. In the past, many of the specialty societies have held luncheon meetings, and in the past doctors have had difficulty getting into hotel dining rooms for a quick lunch.

This year, all doctors will be able to purchase a luncheon ticket for a big buffet lunch in the MSMS Exhibition Hall. This idea appealed to the specialty societies, and they have scheduled no luncheon meetings. Some of the specialty societies, as in the past, will have dinner meetings.

The MSMS staff has arranged with the hotel management to provide a tasty, attractive luncheon buffet, so the doctors may go through the line anytime between 11:30 and 1:00 and sit with any of their friends or morning instructors.

The exhibition hall will be in one of the large rooms at the Hyatt Regency. There will be ample room for the exhibits, for the MSMS registration activities, and for luncheon tables that will seat up to 300.

19 specialty societies involved

The 1976 MSMS Annual Scientific Meeting truly is a cooperative project — with 19 specialty societies participating actively.

When the specialty society representatives gathered early this summer at the Hyatt Regency Dearborn, Robert F. Wilson, MD, annual meeting program chairman, encouraged each to develop a Category I course that would provide new information and learning opportunities.

The specialty society representatives were very cooperative; and they planned courses that would interest both their own memberships and other doctors with interest in their special topics.

All courses and meetings will be open to all doctors in Michigan, on a first-come basis. Advance registration forms will be sent to MSMS members, but later to other doctors who may not have joined their component societies as yet.

Following is a list (in no special order) of the specialty societies that are participating in some way this year:

Michigan Chapter of the American College of Emergency Physicians
Detroit Gastroenterological Society
Michigan Academy of Family Physicians
Michigan Allergy Society
Michigan Society of Anesthesiologists
Michigan Academy of Plastic Surgeons
Michigan Chapter, American Academy of Pediatrics
Michigan Otolaryngological Society
Michigan Orthopaedic Society
Michigan Society of Obstetrics and Gynecology
Michigan Society of Internal Medicine
Michigan Dermatological Society
Michigan Society of Colon and Rectal Surgeons
Michigan Neurosurgical Association
Michigan Society of Therapeutic Radiologists
Michigan Ophthalmological Society
Michigan Psychiatric Society
Michigan Radiological Society
Michigan College of Chest Physicians

And many of the MSMS Sections are sponsoring courses independently, or in cooperation with the closely related specialty society.

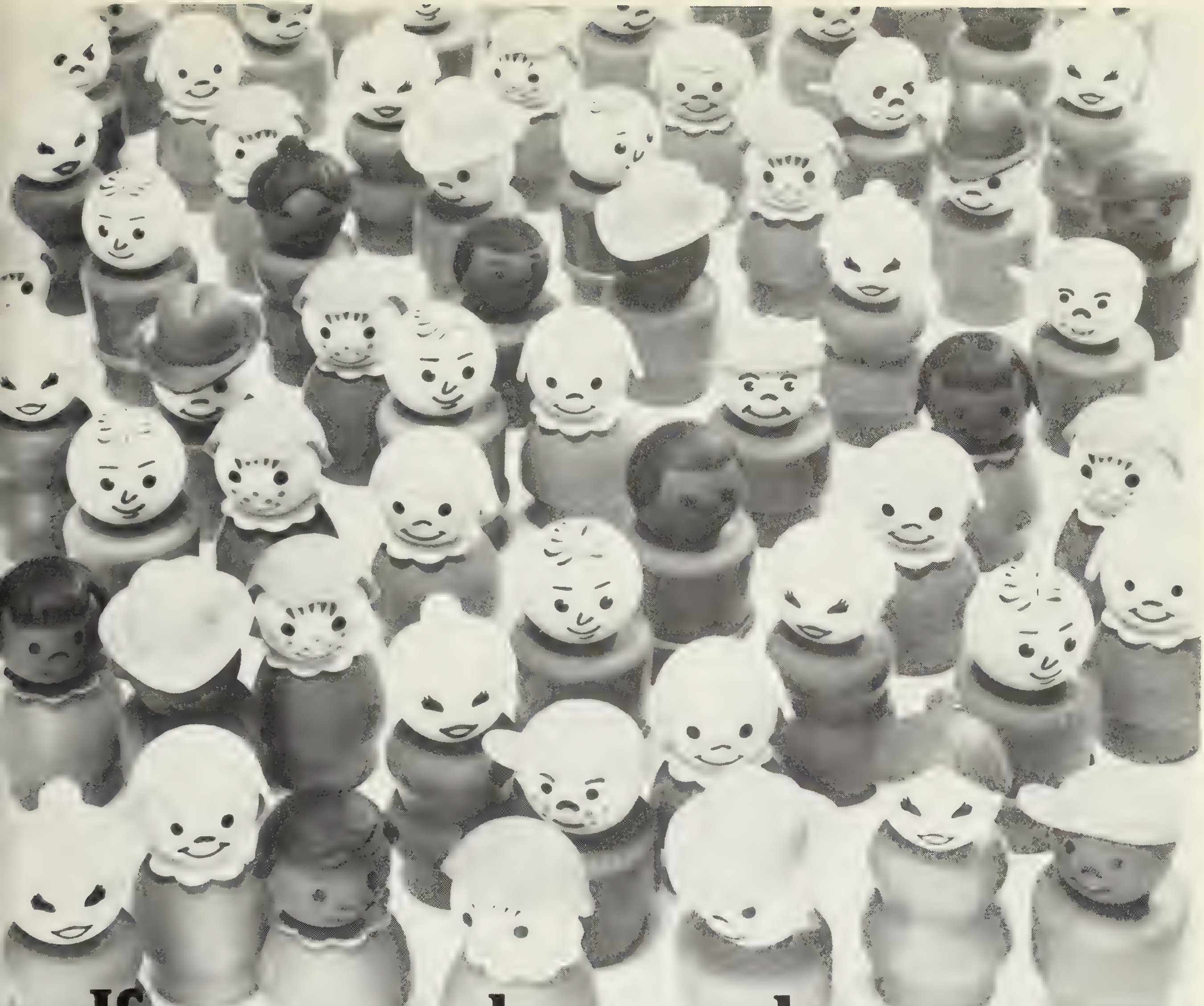
The three Michigan medical schools also are participating in the project, with faculty members of all schools serving as instructors.

Register early

Every MSMS member will be mailed registration forms for the 1976 MSMS Scientific Meeting so the doctor can enroll in one or more of the annual meeting Category I courses, Nov. 9, 10, 11 at the Hyatt Regency Hotel in Dearborn.

For the first time really, MSMS will stress the importance of advance registrations, so plans can be finalized for the room assignments, etc. Every doctor enrolling in the courses will receive a course outline and these must be prepared in sufficient quantities for the registrants.

Doctors are urged to utilize the registration forms that will appear in Medigram in September and October and in other mailing pieces.



If you need a good reason to be a 'par' doctor, we've got more than 5 million.

More than 5 million people in Michigan have Blue Cross and Blue Shield coverage. Which means a good percentage of your patients have prepaid protection that pays for any covered services you provide.

Be a Blue Cross and Blue Shield participating doctor. And say "Yes," when your patients ask if you accept Blue Cross and Blue Shield payments for health care.

We've got a good system and a lot of reasons why it deserves your support.

Join us as a participating doctor. Write Blue Cross and Blue Shield,
Dept. J-706,
600 E. Lafayette,
Detroit, Michigan 48226.
Or call: (313) 225-0685.
Do it today.

Blue Cross
Blue Shield
of Michigan

Letters

"claims for Medicare reimbursement for laboratory services . . ."

In a letter dated May 4, 1976, I asked the help of State medical societies in advising their membership of the legal consequences of rebate arrangements with clinical laboratories in the Medicare program. I am grateful that many of you included information in your routine newsletters. I am writing once again to ask that you consider bringing another matter to the attention of your membership. This relates to claims for Medicare reimbursement for laboratory services.

Medicare reimbursement rules require that the reasonable charge for a laboratory test that was performed by an independent laboratory, but billed by the attending physician, be related to the cost the physician incurred in obtaining the service for his patient. The Medicare carriers are permitted to allow as reasonable a nominal charge by the physician for the drawing of specimens and handling expenses. However, charges representing merely a physician markup of the charges over and above that actually imposed by an independent laboratory for the test itself are improper. Moreover, an independent laboratory not certified to perform a given test under Medicare may not be reimbursed wth Medicare funds even though that test is billed through a physician.

In carrying out their responsibilities, Medicare carriers are required to determine the source of the lab service when the source is not indicated on the physician's bill. Where the service was performed by an independent lab, the carrier must determine that the laboratory is certified by Medicare to perform such tests and the appropriate payment to cover the laboratory's customary charge, rather than the physician's.

Review of Medicare claims indicate that some physicians continue to submit bills for lab tests without showing that the services were actually performed by independent laboratories. We think that it is essential that all of your members are apprised of and understand Medicare requirements, and that there be full disclosure by a physician concerning the source of tests for which payment is claimed under the program. Our aim is to avoid the possibility of physician billing in a manner that could have serious legal consequences.

If you would like us to assist in the preparation of informational materials on this subject, or if you have any questions, please do not hesitate to contact us.

Sincerely yours,
Thomas M. Tierney
Director
Bureau of Health Insurance
Department of Health, Education and Welfare

"during a routine . . . examination . . . it would be advisable . . ."

On at least one occasion during the course of one's employment history, a physical examination is required before one may assume a position. The same requirement must be met for those who plan to attend college. The reasons for this prerequisite are fairly obvious.

What may not be so obvious, however, are the effects of the attitude of the attending physician who performs the pre-employment physical examination. Too often, certain of these physicians display an "I'd-rather-be-anyplace-but-this-service" attitude; the attitude that to be placed on duty in an employee health service is something less than desirable. Such negative feelings on the part of the company physician tend to be conveyed to the prospective employee-patient.

Such methods of dealing with prospective employees can be devastating and cause real harm, and in effect constitute an aspect of malpractice that heretofore may not have been considered. Furthermore, such tactics are a breach of professional ethics and "medical etiquette."

Attempts to respond to such a physician may lead the applicant to:

1. Lose confidence in his personal physician's treatment program and, of significant consequence, his doctor's competence;
2. Discontinue or alter medication regimens;
3. Start the phenomenon known as "shopping," in which a patient begins the time and money-consuming practice of going, with the same ailment, from one physician to another. While second opinions are often necessary and even valuable, running from physician to physician can be considered nothing less than ill-advised;
4. Abandon the idea of seeking medical help because "these doctors can never agree on anything."

During a routine pre-employment physical examination, even if the physician in charge has serious questions about the kind of care the applicant has been receiving, it would be advisable for him to:

1. Explain to the individual, without any evidence of a value judgment, the findings of the examination;
2. Ask the applicant if his regular physician has mentioned a particular condition, or if the former has ever been treated for the malady in question (it is quite possible that the applicant's personal physician may have overlooked something, or that a new condition exists at the time of the pre-employment physical that did not exist when the prospective employee last visited the doctor);
3. Suggest that the patient visit his private physician again for re-evaluation;
4. Offer to be available for a consultation with the applicant's personal physician.

Such an approach to this situation would prove beneficial to both physicians and the applicant-patient, and leaves room for open communication among all concerned parties.

Cheryl A. West, AB, Detroit
Edsel B. Ford Institute
for Medical Research

" . . . gratifying to see my feelings and thoughts expressed so clearly."

The letter to the Editor of MSMS for May, on retired physicians, and new CME requirements (by Richard D. Mudd, MD, Saginaw) expressed my feelings and thoughts exactly. It was certainly gratifying to see them expressed so clearly.

I have managed to pay my dues and registration fees so far and have had the pleasure of two or three consultations a year and that many prescriptions, none of which involved controlled substance.

With a fixed income it is impossible for me to pay tuition fees and motel expenses, etc, to accumulate 50 hours of credit.

Perhaps the Medical Practice Board and active members of MSMS have not given any thought to their retirement.

After plaques and honorariums, deeply appreciated, to face as you so well put it "removal from the mainstream of medical practice," does something to your morale.

With appreciation,
Robert M. Bradley, MD
North Port, Fla.

PACEMAKING For Primary Care Physicians

Pacemaker therapy for conduction disturbances of the heart is a rapidly growing therapeutic modality. This one day course has been designed to provide the primary care physician with an updated comprehensive view of conduction disturbances and management. A distinguished faculty will present concepts, techniques and **indications for temporary and permanent pacemakers** in adults and children, as well as methods for the **long-term evaluation** of the patient with an implanted pacemaker.

- **The American College of Chest Physicians urges you to register now to reserve your space for this concentrated postgraduate course on pacemaker therapy.**

November 10, 1976
Holiday Inn/O'Hare
Chicago, Illinois

APPLICATION FOR ENROLLMENT

AMERICAN COLLEGE OF CHEST PHYSICIANS
911 Busse Highway Park Ridge, Illinois 60068

NAME
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Please send further information ☐
TUITION $40.00 (Including Lunch)
PAYMENT

6 hours CREDIT toward the American Medical Associations Physician's Recognition Award under Category 1.

Should I, or should I not, join a group practice?

(From the MSMS Bureau of Economics)

The following presentation of pros and cons should prove helpful to the physician debating group practice.

Advantages to the Patient

The most tangible patient benefits claimed by proponents of group practice are:

1. The availability of various specialists and technical services in one location;

2. A better assurance of emergency service when needed because of planned full-time coverage;

3. The accumulation of a patient's complete medical history in one file;

4. Access to trained administrative personnel in handling insurance problems or financial difficulties.

Disadvantages to the Patient

But, as most realistic proponents of group practice realize, no human organization is without flaw, and group practice has its share. Some of the reported disadvantages from the patient's point of view are:

1. Group practice may tend to limit the patient's freedom of choice. The patient may like one or more of the physicians, but not some others, and consequently avoid the entire group.

2. It is sometimes asserted that group practice dilutes the intimacy of the patient-doctor relationship because of the informal manner in which group members consult with one another, and the more extensive use of aides and ancillary personnel in handling patients of the group.

3. Patients occasionally have an unhappy contact with the business office, which leads them to condemn the entire organization.

4. The frequent complaint of patients against modern physicians generally — that they are too scientific and frequently oblivious to the psychic or personal needs of the patient — is likely to be heard more often about the group practitioner than about the solo practitioner.

Advantages to the Physician

Some of the specific advantages of group practice most frequently claimed by those who practice in groups are:

1. The ability to work a regular work week, with dependable opportunities for leisure;

2. The opportunity to leave one's practice temporarily for such purposes as professional meetings, educational courses, and vacation with full assurance that one's patients will be cared for;

3. The availability and accessibility of technical aides and facilities and the availability of competent business management;

4. The ease of accessible consultation;

5. The privilege of devoting one's energies to purely professional problems, without concern for administrative matters;

6. The professional stimulus of group relationships in maintaining high quality and improving performance;

7. The sense of professional — as well as economic — security. Group practice is said to offer a comforting check on the possibility of error and a friendly support in adversity;

8. The opportunity to enter practice without a heavy professional investment and with a reasonable assurance of a stable income;

9. The ability to acquire and use the best available equipment for diagnosis and therapy, research, and for administrative functions.

Disadvantages to the Physician

There are some disadvantages of group practice for physicians. A few may apply only to certain individuals; others should be carefully considered by any physician contemplating group practice.

1. "Outside" physicians are sometimes said to be reluctant to refer a patient to a specialist member of a group for consultation.

2. Potentially high-earning specialists seldom realize as much professional income in group practice as they would in solo practice since group practice economics usually result in high-earning members sharing some of their earnings with other partners whose work, though equally necessary, is not so remunerative.

3. Each group member shares in, and suffers to some degree by, the errors of his associates — and they from his.

4. Each group member must temper or curb his urge to individualistic expression at times. There are rules to be observed if one is to function as a member of the team.

5. Each group member will occasionally find himself committed by group decision to policies or decisions of which he disapproves.

6. Group practice sometimes leads to an undesirable degree of overspecialization in practice.

7. There is possibility of disagreement over division of professional income.

SOURCE: The Business Side of Medical Practice, *American Medical Association.*

DYAZIDE®

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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*

LOWERS BLOOD PRESSURE
CONSERVES POTASSIUM

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Warning
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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When Big Ben looks "a little off"...

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

▪ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

▪ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

▪ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

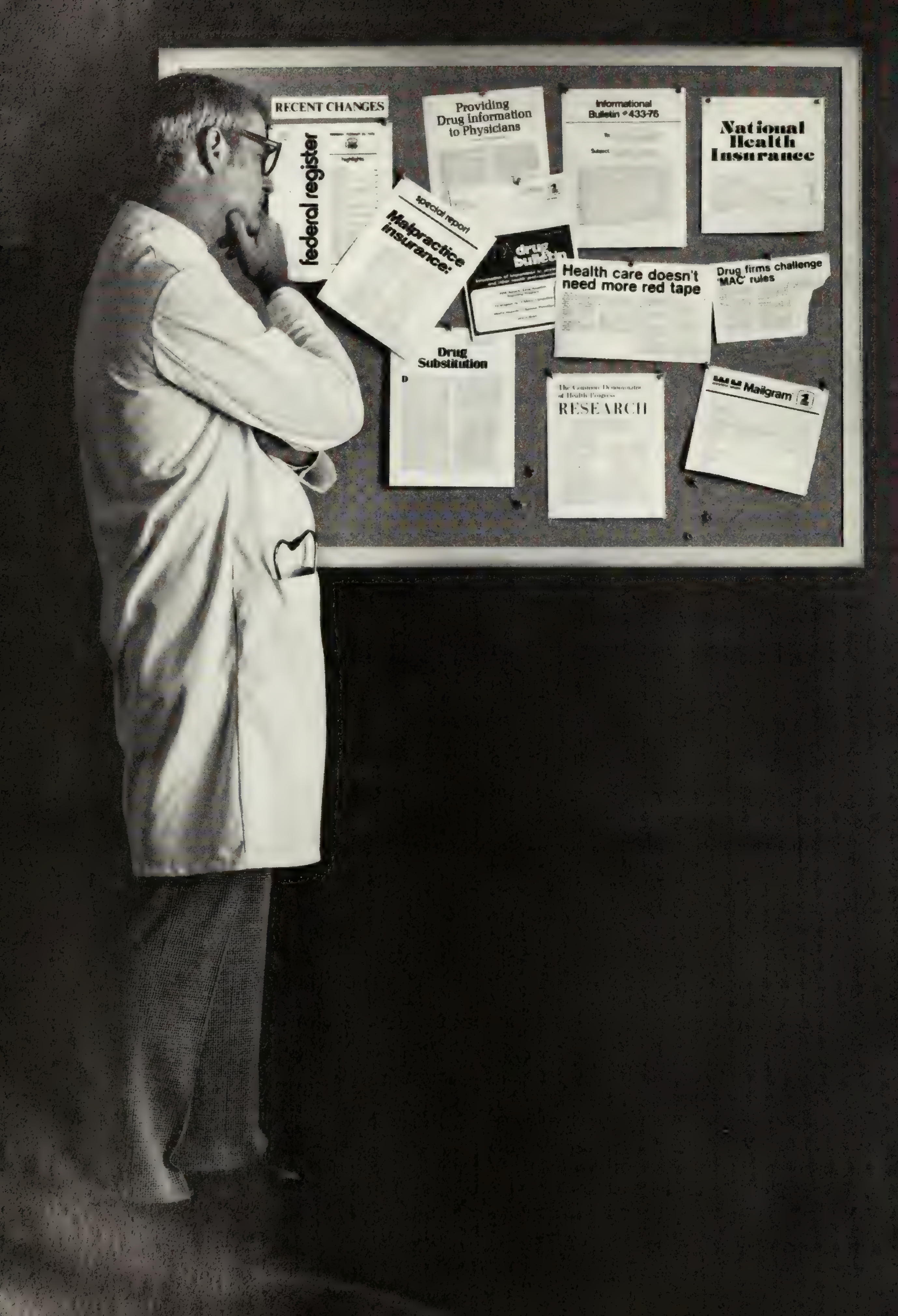
Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



RECENT CHANGES
federal register
highlights
Providing Drug Information to Physicians
Informational Bulletin #433-76
To
Subject
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Physicians can do something about child abuse

By Judith Marr
Managing Editor

"I talked with a father last night who made me so angry.

"But at least I was able to use the few skills that study has given me and prevent myself from blowing up, which I wanted to do; and which at this point would not have done this man or his daughter who was in the hospital with bruises, any good at all."

The speaker was pediatrician Ray E. Helfer, MD, professor, Department of Human Development, MSU College of Human Medicine. He's a nationally-recognized authority on child abuse.

He was discussing physicians' problems in dealing with suspected cases of child abuse, which was the subject of a daylong continuing medical education seminar this spring at MSU. Doctor Helfer called the seminar "a beginning" in the effort to make physicians more aware of the problem and activists in its solution.

The seminar was not to make the participating physicians specialists in neglect and abuse, he explained, but to teach them the kind of information and skills they need to help families involved.

"There are so many gut feelings involved when you talk with people involved in these problems," Doctor Helfer says. "But the more I know about the basic underlying dynamics and pathology, the easier it is to relate to them."

Doctor Helfer first began to study the child abuse syndrome — which he calls only the presenting symptom of a broad, general underlying problem of how the child is being treated in general — when he became head of the University of Colorado pediatrics department in 1964. One-fourth of his salary came from a grant to study child abuse.

"I found the study interesting and challenging," comments Doctor Helfer, father of six children.

Since then he has become a national authority, co-author of two widely-hailed books, *The Battered Child,* and *Helping the Battered Child and His Family.* A recent article on child abuse in *American Medical News* quoted Doctor Helfer twice. He has written numerous articles on various aspects of the subject and participated recently in the first international conference on child abuse.

What physicians should do

Doctor Helfer has some very definite opinions on what physicians can and must do to cure the "disease" of child abuse.

(1) Physicians must recognize that child abuse is only a symptom of the underlying problem — "a very serious developmental dysfunction on the part of the parents.

"It has to do with the parents' failure to have experienced any reasonable, rational early childhood development," he says. "They have not learned, and are not teaching their own children, (a) the ability to set priorities, (b) that each has self worth, and (c) how to interrelate with others. They do learn that people hurt and they learn tremendous skills of making sure people don't get too close to them."

(2) Physicians must recognize the magnitude of the problem.

"Every year, approximately one percent of Michigan children are reported as suspected cases of child abuse and neglect. That's 24,000 children per year and the figure is accumulative. Some of our studies show that 20-25% of our children altogether are going to have problems."

Physicians interviewed in the *AMNews* article estimate child abuse as very likely the leading cause of death among children today. Two children die daily across the country from battering.

(3) Physicians must recognize they can do something about child abuse.

In Michigan, the law compels physicians to report suspected cases of child abuse and neglect. The doctor is not required to investigate or make charges, but only to report his suspicions.

Why physicians don't get involved

In a recent article published in *Children Today* magazine, Doctor Helfer outlined eight reasons he believes physicians are "truly reluctant" to become involved in the area of child abuse and neglect: (1) Medical school training was insufficient; (2) physicians are not trained in interpersonal skills; (3) doctors have great difficulty working with members of other disciplines as peers; (4) the drain on time, finances and emotions for the physician in private practice is truly extensive; (5) physicians have a fear of testifying in court; (6) there is minimal personal reward and these rewards are hard to identify; (7) when one does get involved he or she is often confronted with a community service system that is less than helpful, and (8) physicians rarely have been trained to see themselves, or to act, as agents for change.

Doctor Helfer went on to recommend that all physicians be trained in the area of child abuse and neglect, pediatrics specialists be trained further and these pediatric consultants be subsidized and affiliated with a community and/or hospital-based, multidisciplinary child protection team.

"Eventually, one or two pediatric specialists in child abuse must be an integral part of every protective ser-

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Ann Arbor, Michigan
September 29-October 2, 1976

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Ann Arbor, Michigan

Course Director:
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Associate Director
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Credit:
28 hours credit toward the American Medical Association Physician's Recognition Award under Category 1.

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- Mechanisms of Pulmonary Hypertension
  Norman C. Staub, M.D.
- Pulmonary Emboli
- The Preoperative Evaluation of Patients
  Myron Stein, M.D.
- **For further information contact:**

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CHILD ABUSE/*Continued*

vices program in the country," he wrote.

"There are very good reasons why physicians are reluctant to become involved in the problem of child abuse and/or neglect. And this situation must be changed. (Actions such as those mentioned above) will move us a long way toward overcoming the problem of minimal involvement on the part of physicians."

Physicians must have cooperation

"But this is not a solo operation," he emphasized at the opening of his workshop for physicians this spring. "There is no way the individual can function in this area himself."

The father who had brought his bruised daughter into the hospital the night before had made Doctor Helfer angry. "And I was so frustrated," he said, "because you should not have to deal with such a case alone, and I was alone. I could go only so far with my skills as a pediatrician. He clearly needed a psychiatrist, social worker, etc."

"We must force people to implement what is known to be needed," he says. "I will, as a pediatrician, give health care, but I can't do it all together. We have got to demand the services for the community that our families need. We must work together."

Doctor Helfer says he believes there is more child abuse and neglect now than ever before. We are more aware of the condition, also, he says.

But he says he has turned his anger away from the people perpetrating the abuse to the bureaucracy which "can't get on with what needs to be done."

And he challenges Michigan physicians to get on with the task also.

Why does the MSMS not see this as high priority? Doctor Helfer asks. "If we had 24,000 cases of anything else that had such a disastrous affect on children in Michigan, the state medical society would be up in arms."

Doctors should get involved with the community to "jazz up" the after-the-fact services, Doctor Helfer says. And they've got to get involved with early recognition and prevention of high risk abuse situations.

Doctor Helfer

"There is enough knowledge to identify families with high risk action programs," he says. "There is no excuse for physicians to deliver babies and then be willing to send them home to environments they know are going to be disastrous.

"We as an organized group shouldn't put up with this. Those delivering care have got to make more noise."

Doctor Helfer has no sympathy for physicians who "sit back and complain because other service agencies won't do anything about child abuse. Let's get on with it, let's do something, let's get involved!" he challenges.

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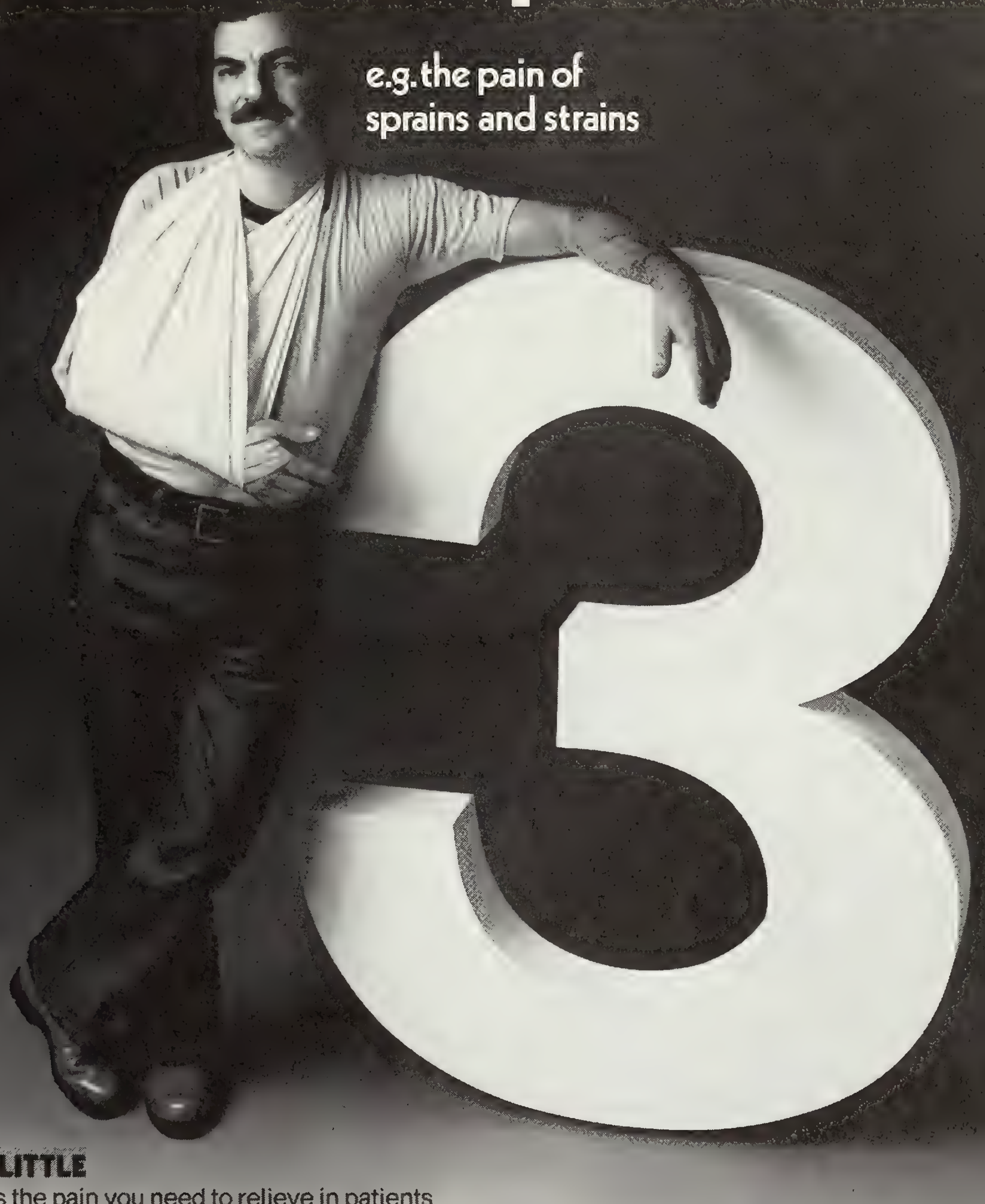
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category 1 programs

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

DATE: Sept. 13-17, Third Annual Family Practice Review
LOCATION: Scott Hall, WSU
SPONSOR: Department of Family Medicine, WSU
CO-SPONSOR: Michigan Academy of Family Physicians
FOR: Family physicians — interested physicians
COST: $150.00
CONTACT: Sally Bates, Department of Family Medicine, WSU (313) 577-1420
APPROVED FOR: 40 Hours of Category I Credit

* * *

DATE: Sept. 13-18 — Endoscopy Workshop, Third Regional Meeting
LOCATION: North Detroit General Hospital
SPONSOR: North Detroit General Hospital
CO-SPONSOR: International College of Surgeons
FOR: Surgeons
COST: $100 staff, 200 non-staff, 500 non-staff actually doing endoscopy surgery
CONTACT: D. Meyer O. Cantor, 3105 Carpenter, Detroit, 48212
APPROVED FOR: 45 hours of Category I Credit

* * *

DATE: Sept. 13-Nov. 22 — Seminars in Perinatology
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit 48236
SPONSOR: Saint John Hospital
FOR: All interested physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 20 Hours of Category I Credit

* * *

DATE: Sept. 15, Annual Muskegon Trauma Day
LOCATION: Holiday Inn, Muskegon
SPONSOR: Michigan Committee on Trauma, American College of Surgeons
CO-SPONSOR: Muskegon County Medical Foundation
FOR: All interested physicians
COST: $15
CONTACT: G. W. Annessa, MD, 1470 Peck St., Muskegon 49441
APPROVED FOR: 6 hours of Category I credit

* * *

DATE: September 15, Otolaryngologic Problems in Family Practice
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: Michigan Academy of Family Physicians
COST: $60
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 7 hours of Category I credit

* * *

DATE: September 17-18, Psychiatry Conference, "Diagnosis and Management of Adult Psychiatric Syndromes"
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $80
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: Sept. 17-18, Therapeutic Gastrointestinal Endoscopy
LOCATION: Michigan Inn, Southfield
SPONSOR: Michigan Society for Gastrointestinal Endoscopy
CO-SPONSOR: American Society for Gastrointestinal Endoscopy
FOR: All interested physicians
COST: $125 for members; $150 for non-members; $75 for physicians-in-training
CONTACT: William P. Maloney, Executive Secretary, American Society for Gastrointestinal Endoscopy, 6 Beacon Street, Suite 620, Boston, Mass 02108
APPROVED FOR: 10 Hours of Category I Credit

* * *

DATE: Sept. 17-18, Problems in Medical Management II
LOCATION: Howard Johnson Motor Lodge, Port Huron
SPONSOR: Henry Ford Hospital
FOR: Family Physicians
COST: $60
CONTACT: Medical Education Office, Henry Ford Hospital
APPROVED FOR: 7 Hours of Category I credit

* * *

DATE: Sept. 22, Allergy & Immunology Seminar
LOCATION: Saint John Hospital, 22101 Moross Road, Detroit, MI 48236
SPONSOR: Saint John Hospital
FOR: Allergy — Immunology
COST: $50
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital
APPROVED FOR: 7 Hours of Category I Credit

* * *

DATE: Sept. 22-24, Blood Coagulation Techniques
LOCATION: Towsley Center for Continuing Medical Education, Ann Arbor
SPONSOR: Office of Intramural Education, Dept. of PGM/HPE
FOR: Hematologists, pathologists, surgeons and hematology technicians.
COST: $150

CONTACT: Office of Intramural Education, Dept. of PGM/HPE, University of Michigan
APPROVED FOR: 19¼ Hours of Category I Credit

* * *

DATE: Sept. 22-24, Recent Advances in Neurology
LOCATION: McGregor Memorial Center, Wayne State University
SPONSOR: Wayne State University Department of Neurology
FOR: All interested physicians
COST: $150
CONTACT: Beverly Wolf, Department of Neurology, 3990 John R, Detroit, 48201
APPROVED FOR: 18 Category I credit hours

* * *

DATE: Sept. 25, Problems in Medical Management II
LOCATION: Buerki Auditorium, Henry Ford Hospital, Detroit
SPONSOR: Henry Ford Hospital
FOR: Family Physicians
COST: $50
CONTACT: Medical Education Office, Henry Ford Hospital
APPROVED FOR: 7 hours of Category I credit

* * *

DATE: Sept. 24-25, The Perinatal Association of Michigan Annual Conference on Important Topics in Perinatal Health
LOCATION: Kellogg Center, East Lansing
SPONSOR: Perinatal Association of Michigan
COSPONSOR: MSU College of Human Medicine
FOR: Family physicians, obstetricians-gynecologists
COST: $10
CONTACT: Eugene A. Dolanski, MD, Department of Human Development, MSU College of Human Medicine
APPROVED FOR: 6½ hours of Category I credit

* * *

DATE: Sept. 28, New Concepts in Nutrition
LOCATION: Hospitality Inn (Cascade Road) and Butterworth Hospital, Grand Rapids
SPONSOR: MSU College of Human Medicine, GRAMEC and American Society for Parenteral and Enteral Nutrition
FOR: All interested physicians
COST: $35.00
CONTACT: Richard Dean, MD, (616) 459-2837 GRAMEC
APPROVED FOR: 9 Hours of Category I Credit

* * *

DATE: Sept. 28, Recent Advances in the Pathophysiology and Therapy of Low-Flow (Shock) States
LOCATION: Stanley Wing Auditorium, Ingham Medical Center, Lansing
SPONSOR: Ingham Medical Center and Michigan State University
FOR: All interested physicians
COST: None
CONTACT: Ingham Medical Center**
APPROVED FOR: 1 Hour of Category I Credit

* * *

DATE: Sept. 29, Infectious Disease Symposium
LOCATION: E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing
SPONSOR: E. W. Sparrow Hospital
FOR: All physicians
COST: None
CONTACT: Sparrow Director of Medical Education***
APPROVED FOR: 4 hours of Category I credit

* * *

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Richard D. Watkins, M.D.
Robert M. Zimmerman, M.D.

DATE: Sept. 29-30 — Quality Assurance Tutorial
LOCATION: CPHA — Ann Arbor
SPONSOR: Commission on Professional and Hospital Activities
FOR: Physician teams from member institutions
COST: $155 per hospital (Five-member team): $35 each additional team member.
CONTACT: CPHA, 1968 Green Road, Ann Arbor 48105
APPROVED FOR: 12 Hours of Category I Credit

* * *

DATE: Sept. 29-Oct. 2, Acute Respiratory Failure: Mechanisms and Management
LOCATION: Towsley Center, U of M, Ann Arbor
SPONSOR: American College of Chest Physicians
CO-SPONSOR: University of Michigan Medical School
FOR: Thoracic Surgeons
COST: ACCP Members: $160, Nonmembers: $185, Residents, Nurses & Therapists: $125
CONTACT: American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068, (312) 698-2200
APPROVED FOR: 28 Hours of Category I Credit

* * *

DATE: Oct. 1-2 — Annual Meeting of Burns Clinic Medical Center
LOCATION: Boyne Highlands Resort, Harbor Springs
SPONSOR: Burns Clinical Medical Center, PC/Little Traverse Hospital
FOR: All physicians
COST: $50
CONTACT: Ernest W. Carpenter, MD, Chairman, 560 W. Mitchell, Petoskey 49770
APPROVED FOR: 10 Hours of Category I Credit

* * *

DATE: Oct. 1-3, Regional Meeting — American College of Physicians
LOCATION: Hidden Valley Resort, Gaylord
SPONSOR: American College of Physicians — Regional
FOR: All interested physicians
COST: $15 for members; $18 for nonmembers; No charge for physicians in training
CONTACT: B. C. Payne, MD, (313) 763-1202
APPROVED FOR: 13½ Hours of Category I Credit

* * *

DATE: October 5, Continuing Pathology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: Undetermined
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: Oct. 6 — Adolescence
LOCATION: Mott Community College (Bower Theatre), Flint
SPONSOR: Michigan State University of Human Medicine *and* Mott Children's Health Center
FOR: (specialties) Family Physicians, Pediatricians, Internists.
COST: Approximately $10
CONTACT: Lucy Jeffers, Flint Medical Education Center, 420 S. Ballenger Hwy, Flint
APPROVED FOR: 4 Hours of Category I Credit

* * *

DATE: October 12-13, Diabetes Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education

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143 Cortland Avenue, Rockford, 49341, Telephone (616) 866-9395

COST: $60
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 13½ hours of Category I credit

* * *

DATE: October 14-16, Family Practice Review
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: Michigan Academy of Family Physicians
COST: $170
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: October 19-21, Cardiology for Internists
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $170
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: October 22-23, Psychiatry Conference, "Common Problems in Child and Adolescent Psychiatry"
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $80
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: Oct. 28-30, The Human Vagina: biological and clinical aspects.
LOCATION: Wayne State University
SPONSOR: WSU School of Medicine
FOR: Gynecologists, Family physicians
COST: $100
CONTACT: WSU
APPROVED FOR: 45* pending Hours of Category I Credit

* * *

DATE: November 8-9, Abnormal Hemoglobin and Thalassemia
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: American Society of Medical Technologists
COST: $70
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 15 hours of Category I credit

* * *

DATE: November 9-10-11, Michigan State Medical Society Annual Scientific Meeting
LOCATION: Hyatt Regency Hotel, Dearborn
SPONSOR: MSMS Committee for CME Programming
FEATURING: 36 Category I Courses, sponsored by statewide medical specialty societies and the MSMS Committee; taught by outstanding Michigan medical educators and practitioners and out-of-state authorities.
COST: $5 per credit hour for MSMS members; $10 per credit hour for non-members; no charge for residents and interns.
CONTACT: Herbert A. Auer, MSMS
APPROVED FOR: Category I credit; maximum during three days would be 25.
REGISTRATION: Registration forms, etc., will appear in early September MSMS Medigram.

* * *

DATE: November 17-18, Second Annual Pulmonary Seminar for Family Physicians
LOCATION: Harper/Webber Auditorium, Detroit Medical Center
SPONSOR: WSU School of Medicine, Departments of Family Medicine, Internal Medicine-Pulmonary Division, Pediatrics, and Div. of Postgraduate and CME; Michigan Academy of Family Physicians; American Lung Association of SE Michigan
FOR: All interested physicians
COST: $60.00
CONTACT: Miss Gibson or Mrs. Murray, American Lung Association of SE Michigan (313) 961-1697
APPROVED FOR: 16 Hours of Category I Credit

* * *

(Continued on page 506)

The following have been accredited by MSMS Commission on Continuing Medical Education as of Sept. 1, 1976.

Organizations:

Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Detroit-Macomb Hospital Association
Grace Hospital, Detroit
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Providence Hospital, Southfield
Saginaw Cooperative Hospitals Inc., Saginaw
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
Sinai Hospital of Detroit, Detroit
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Wayne County Psychiatric Hospital, Eloise
Ypsilanti State Hospital, Ypsilanti

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NDC 19-R515-69, gallon bottle.

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REFERENCES

1. McColl, J. D., et al.: **J. Pharm. & Exp. Therap.** 116:343, 1956
2. Quevauviller, Par Andre, et al.: **Presse Med.** 61:1480-1482, 1953
3. Maney, P. V., et al.: **J. Am. Pharm. Assoc.** 35:266-272, 1946

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DATE: Nov. 26-29, Ophthalmology: Basic and Clinical Review
LOCATION: Dearborn Inn
SPONSOR: Kresge Eye Institute, WSU School of Medicine
FOR: Ophthalmologists
COST: $400
CONTACT: Arthur Sapere, Program Registrant, McGregor Memorial Conference Center, Wayne State University, Detroit, 48202
APPROVED FOR: 40 hours of Category I credit

Continuing Courses

DATE: November 23, Continuing Pathology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: Undetermined
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

* * *

DATE: Every Friday, through June, 1977, Neurology Conference
LOCATION: 4 Morse Auditorium, Harper Hospital
SPONSOR: Wayne State University Department of Neurology
FOR: Internists, neurologists, neurosurgeons, pediatricians, family doctors
COST: None
CONTACT: Beverly Wolf, Department of Neurology, 3990 John R, Detroit, 48201
APPROVED FOR: 2 Category I hours

DATE: Every Saturday, Weekly Conference
LOCATION: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey
SPONSOR: Burns Clinic/Little Traverse Hospital
FOR: All interested physicians
COST: None
CONTACT: Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770
APPROVED FOR: Hour-for-hour Category I Credit

* * *

DATE: Begins September, 1976, Continuing Training in Family Therapy
LOCATION: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield
SPONSOR: Family Institute of Southeastern Michigan
CO-SPONSOR: Ackerman Institute
FOR: Psychotherapists
COST: Varies according to time put in
CONTACT: Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan
APPROVED FOR: Hours vary with time spent

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**Mary Hollandsworth, Department of CME, Ingham Medical Center, 401 West Greenlawn, Lansing, MI 48910

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

Medical Protective clarifies rates, status in Michigan

The following is a statement sent to MSMS headquarters by the Medical Protective Company of Fort Wayne. The statement clarifies Medical Protective's plans for increasing rates and spells out Medical Protective's status in Michigan. The statement was prompted by a letter sent early in August to Detroit-area physicians by the Physicians Crisis Committee, in which PCC leaders predicted large rate increases by Medical Protective.

It has come to our attention that there is some misunderstanding of what was said at recent insurance department hearings regarding the Company's plans for future rate levels, underwriting attitude and our long-range plans.

First, and most important, the Company is not planning and does not wish to cease doing business in the State of Michigan. Our attitude, as demonstrated in our testimony during the recent department hearings, has always been one of cooperation and of conducting our business with the best interests of the medical community and our policyholders, in particular, at heart.

Our statistics and other pertinent information are, always have been, and will continue to be, on file with the department and are supplemented, to every extent possible, in response to requests from the department and the medical community.

We have just concluded a total limits rate study and the indication is that a very moderate increase (less than 20%) will be requested effective early in 1977. The increase is due to adverse underwriting experience in the high limit area.

We value the long-standing relationship with our policyholders in Michigan and value their loyalty. We pledge every effort to continue our service and to merit the confidence that so many Michigan physicians have placed with us.

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[1] Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976.

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(The following two articles present two viewpoints of the increasingly important subject of the cost of medical care. Their thoughtful analysis should aid MDs in better understanding the problem.)

Medical care costs

How big is the increase? What's the cause? Is there an answer?

By Max H. Parrott, M.D.
AMA Past-President

No one really *enjoys* a medical bill.

Charges for the traditional necessities — food, clothing and shelter — can generate a degree of pleasure or fulfillment. But even the most glowing health report rarely evokes joy when the bill arrives. Medical payments, like taxes, create neither creature comforts nor ego satisfactions.

And when medical costs rise, as they have been doing, people display more than their customary frustration with such economic behavior.

In turning a clear eye on what has been happening to medical costs it is therefore well to skip over the emotional factors and focus on the hard facts.

The Consumer Price Index tells us that in the last five years the component for medical care has risen 39.8 percent, with physician fees increasing 39.5 percent. That is more, *but not dramatically more,* than the 38.6 percent rise for all items or the 37 percent rise for all services. The CPI ignores significant increases in the quality of care — new technology and more sophisticated treatments for disease, for instance. But it is still as good an indicator as we have. From 1970 to 1975 total U.S. expenditures for health, which include everything from brain surgery to medicated shampoo, have grown from $69.2 billion to $118.5 billion, a jump of 71.2 percent.

Not a particularly welcome total. But just how do such boxcar figures translate into impact on a family budget? Below is a table showing what has happened to an intermediate family of four.

The intermediate family spent 6.5 percent of its after-tax income on medical care in 1970, 6.6 percent in 1975 — scarcely a dramatic surge.

What alarms many people about health care costs is not so much what has happened as what could happen. In 1975 medical care components rose at an annual rate of 12 percent on the Consumer Price Index, compared to 9.1 percent for all items and 9.5 percent for all services.

What Fuels the Inflation?

There are no simple answers. But we can identify the more dynamic inflationary forces.

Health insurance: No one knows whether we have a "free enterprise" health care system or a "socialized" system. But we know we have a highly regulated system. And we know we have an *insured* system. Insurance pays nine out of ten hospital bills, 65 percent of physician care expenses. Twenty-five years ago the patient paid about two-thirds of his medical expenses. Today he pays less than one-third in out-of-pocket costs.

Medical costs are a unique element in our economy. For every other purchase the American consumer uses his own earnings, savings or credit. But for medical "purchases" the consumer generally does not act in the

Doctor Parrott

DOCTOR PARROTT/*Continued*

role of classic economic man, for he is not, by and large, spending his own money. Health insurance has removed or sharply modified one classic brake on demand — consumer price restraint.

By emphasizing hospital benefits rather than less expensive ambulatory care, health insurance exerts another upward pressure on cost.

Government programs: Medicaid, Medicare, and other government medical care programs add massive fuel to demand. These programs now sluice $50 billion annually into the health care system with expenditure controls that can hardly be described as taut.

To hold down costs, the federal government arbitrarily reimburses hospitals and physicians at rates determined by the experience of earlier years. To compensate, hospitals and physicians are under economic pressure to raise rates and fees more frequently. Government medical payments are thus *twice-subsidized*, first by taxes and then by increased charges to non-government patients. The effect is the familiar, upward spiral.

Wider eligibility and broadened benefits: These have also shot federal costs up. Without the passage of major health legislation, federal health expenditures have *doubled* since 1970. And without a major shift in the U.S. economy, the number of people receiving Medicaid benefits, now 32.5 million, has *tripled*.

Even without any increase in prices in the last five years, government medical spending would have risen 45.2 percent.

Demographic changes: Changes in the population are working against medical care costs. The U.S. is becoming not only a more populous nation but an older nation, and older people require more medical care. The oldest 10 percent of the population accounts for more than 33 percent of inpatient hospital days.

Hospital costs: These costs exert tremendous impact, for they represent about 39 percent of all U.S. health dollars (compared to the 19 percent for physicians, 9 percent for drugs and drug sundries, 8 percent for nursing home care and 6 percent for dentists). Demand factors, created by the growing availability of insurance, are principally to blame for the upward pull on hospital costs. In addition, hospitals have been hit by general inflation as few other segments of the economy. The market basket of things a hospital buys are items whose prices are increasing far *more* rapidly than the items measured in the Consumer Price Index. Hospital payroll costs — a large factor in a hospital budget — have gone from $33.16 per patient day in 1970 to $72.34 in 1975, an increase the consumer ultimately absorbs.

FAMILY BUDGET	**1970**	**1975**	**$ change**	**% change**
Before taxes	$10,664	$15,318	+$4,654	+43.6%
After taxes	8,744	12,427	3,684	42.1
SPENT FOR . . .				
Food	2,452	3,827	1,375	56.1
Housing	2,501	3,533	1,032	41.3
Transportation	912	1,279	367	40.2
Clothing, personal care	1,137	1,433	296	26.0
Other family spending	639	831	192	30.0
Charity, life ins., etc.	539	701	162	30.1
Taxes, etc.				
Social Security taxes	387	834	447	115.5
Income taxes	1,533	2,057	524	34.2
Medical Care	564	822	258	45.7

Source: U.S. Bureau of Labor Statistics

Malpractice: The premiums that physicians and hospitals pay for liability insurance are beginning to drive up costs. Rates for physicians have jumped 148 percent in Illinois, 168 percent in New York and as much as 400 percent for some doctors in California. Michael Reese Hospital (Chicago) now spends $3 per room per day on liability insurance. Next year it will be $16.50.

Are Controls the Solution?

Solutions, of course, are what we all are looking for. There seems to be no single, simple solution.

Controls, if they work at all, will only work longterm if prices *and* wages are controlled throughout the economy as a whole. New methods of delivering care should be tried. We have a pluralistic system now, and we should continue new approaches. Various forms of utilization review are in place, in development or under study. Closer agreement must be reached on how to plan effectively on a voluntary basis, cut duplication and distribute facilities more efficiently.

Physicians must better acquaint themselves with the cost of the procedures they order for patients, then take a flintier look at the cost/benefit ratio. They can make less costly decisions *if the threat of malpractice is better contained*. Review procedures, such as the current vogue for "second opinions," must be understood for what they may turn out to be: the denial of services desired by the patient or judged by his physician to be necessary.

The Medical Troika

The hard fact is that medical care costs have to be considered along with at least two other, equally important factors — the accessibility of medical care to the whole population and quality of the medical care given. These three dynamics — cost, access and quality — form a troika, a three-horse hitch in which the separate horses have to pull harmoniously to pull effectively.

Medical insurance — and especially government medical insurance — has vastly widened access. Very few people now fail to seek medical care because economic barriers block the way.

(Continued on page 512)

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A Non-Regimented INTRAV Deluxe Adventure

Why it costs so much

By Victor Curatolo, MD, Mt. Clemens
President, Michigan Radiological Society

When I first started practice almost 30 years ago, many diagnoses were made on the basis of clinical findings with minimal supportive laboratory or radiographic evidence.

Physicians were hesitant to spend the patient's money unless it was absolutely necessary. Interns and residents were also so instructed (at least in private hospitals). Patients were frugal with their medical expenditures.

Treatment was frequently started by the doctor with a presumed clinical diagnosis and then adjusted or changed as judged by the clinical response. Intra-abdominal surgical problems were treated frequently by "exploratory laparotomy" with no specific preoperative diagnosis and the patients were sent directly from the O.R. to their rooms. No recovery rooms!

Emergency rooms in private hospitals were frequented daily by very few patients (with real emergencies) and these emergency rooms were oftentimes covered by employees whose primary duties were elsewhere within the hospital. Outpatient work was done in physicians' private offices. The patients often treated themselves by home remedies for two or three days and if unimproved would then visit a physician.

How times have changed!

With the advent of more complete and comprehensive medical and hospital insurance coverage, a third force became important in the doctor-patient decision making. Doctors became less conscious of spending money for supportive diagnostic evidence and patients also began to demand more specific diagnostic tests which were not costing them any money (they thought). The number of laboratory, x-ray and other diagnostic procedures began to rise; slowly at first, but eventually skyrocketing.

The frequency of emergency room visits also began to rise and the great

Doctor Curatolo

DOCTOR PARROTT/*Continued*

This emphasis on access, widely accepted as a desirable social goal, has led to more people seeing more physicians (whose numbers increased 18 percent between 1970 and 1975). The impact thus generated has inevitably fallen on the two other horses in the troika, cost and quality.

As far as quality is concerned, there has been no compromise. If anything, the quality of American medicine has improved.

The impact has fallen on cost.

Policy and the Public

The question is really this: Which way does the American public want its medical care? There are three basic choices:

1. The U.S. can have lower cost medical care and, at the same time, universal access to it *if* it is willing to limit the quality of the care given.

2. The U.S. can have lower cost medical care and the present high quality of care *if* it is willing to limit access by shifting more of the financial burden back on the individual.

3. Or the U.S. can provide universal access and the best medical care there is *if* it is willing to accept the high cost.

The third is the option Americans have chosen. I think it is the choice they will continue to make.

If that is the public's choice, then what can be done to bring costs into line?

Right now my feeling is that the best answer is in health education — better knowledge and *especially* better motivation — applied to *personal* health decisions on diet, nutrition, tobacco, alcohol, exercise and emotional stress.

The American Medical Association is concerned along with everyone else over mounting costs. We have recently formed a Commission on the Cost of Medical Care, of which I am chairman. It is a diverse and representative group, not a committee of doctors only. We are concentrating on the basic aspects of the problem. I expect we will soon come up with practical approaches that can moderate costs without jeopardizing quality.

majority of the types of visits became nonemergent.

A factor contributing greatly to this trend was the demise of the general practitioner's office. The patients had to turn to the hospital emergency rooms and this also contributed to increased costs as emergency room visits cost, in total, more than private office visits. Progressive expansion of emergency rooms into emergency room departments doing 90 per cent outpatient type work on a 24-hour basis occurred.

Emergency room visits require immediate, accurate diagnoses for prompt treatment so numerous diagnostic procedures are ordered by the emergency room doctor; many of which are noncontributory to a positive diagnosis but do rule out possibilities, and help in the final disposition of the patient. Some are a substitute for a complete history and physical, which may not be possible at the time.

Also, patients demanded hospitalization earlier and most often because they had insurance. Some had to be hospitalized because their insurance covered a diagnostic service only as a hospital in-patient.

More sophisticated diagnostic tests were developed (angiograms, nuclear studies, etc.) which permitted specific diagnoses previously not possible. New complicated surgical procedures became possible (open heart, complete hip, etc.).

All of this being expensive.

Elaborate equipment and rooms, supportive services and supplies were required and sometimes a team of professional diagnostic workers. These examinations frequently costing over one thousand dollars in total expense. Special service areas such as recovery rooms, intensive care, coronary care and inhalation therapy were developed. Special monitoring and therapeutic equipment became prevalent.

Complicated diagnostic and therapeutic measures continued to mount — all very expensive and sometimes lifesaving.

Then Medicare and Blue Cross began paying 100 per cent plus to the hospitals for their services without any regard to efficiency or economy.

Hospital costs naturally soared. The number of employees were increased. New positions were created (assistant to the assistant, decorators, educators, security people, social workers, etc). No effective cost control was maintained by either the government or Blue Cross and no incentive to save money.

Physicians' costs, in contrast, per individual service were well controlled by Blue Shield with increases at or below inflationary levels.

The number of emergency room visits continued to increase rapidly, as did the number of all diagnostic procedures ordered by the physicians. Patients became more demanding for diagnostic tests, for hospitalization and also for perfect results.

Finally, there was the impact of increasing lawsuits; many encouraged by lawyers and some because patients expect a perfect result every time, not permitting a variation from perfect.

The annual professional liability insurance premium for some physicians rose above the level of the total income of other physicians. The number of diagnostic tests now is increasing because the physicians are practicing defensive medicine worrying about a potential lawsuit rather than expense.

Now, we have so called "diagnostic centers" spreading up like mushrooms which allegedly offer a complete diagnostic service and frequently staffed with inferior equipment and personnel. Most are being operated as a business and not as an ethical profession.

Costs constantly rising due to the causes mentioned but also due to inflation affecting society as a whole.

Where will it end? Can expenses be decreased or controlled? Some can and some cannot.

Let us try — doctors, hospitals, patients and third parties all working together, and not in solitude.

Government should not "punish" medistudents on federal loans

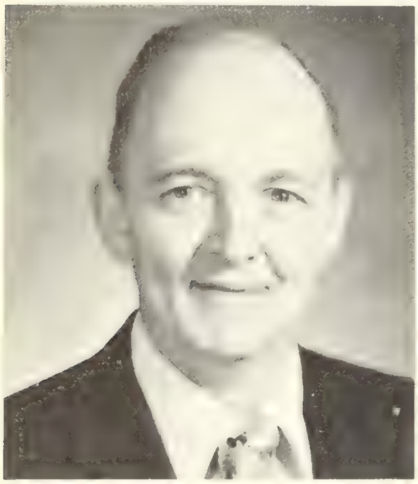
(The following is excerpted from a recent letter to Michigan's U.S. Senators Griffin and Hart, with the author's permission.)

By Jack G. Lukens, MD
Grand Rapids

I think it is obviously unjust to demand of medical students either capitation grant paybacks or an imposition of mandatory federal service, since they were the recipients of capitation grants to medical schools. If the federal government wants to require one or both of these conditions for any student in any State or private center of higher learning which received government money, then, I think, this is perhaps constitutional though undesirable. To require this of one small segment that is receiving some benefit of government expenditures is illogical, and I would feel unconstitutional, and certainly inequitable.

Federal controls have demonstrated in the past their inability to control many things adequately. To place federal controls over residency training programs and the number of physicians that may enter residency

DOCTOR LUKENS/*Continued*



Doctor Lukens

programs is going to force some physicians into residencies that are not their first choice. It will add one more bureau, and, therefore, an increasing amount of expense to a private system that has functioned rather well, though with some inadequacies as any system has. But it seems that any system with inadequacies is attacked now by the federal government as if they have sufficient knowledge and expertise to solve all of our problems.

The States now, quite economically, provide state licensure and relicensure of physicians. If the federal government feels it has some suggestions to improve this system, then why not relate that to the states? But let's please not add one more bureau or a group of offices for this purpose.

Sen. Edward Kennedy's payback by students who receive scholarships also seems unnecessary. At a time when we are selling grain to Russia at below-market price, and offering Russia loans at no interest, 2%, and 4% interest, and all Americans have to pay two to three times that for their money, it does not seem reasonable to punish students who are trying to better their education and thus provide a more solid citizenry who will be able to pay an increasing amount of taxes in their lifetime. If you want to require the payment of interest at a reasonable level, then I think this should be done, but what is the purpose of punishing the student?

The federal government also is considering not taking into account local medical society opinion as to the need for National Health Service Corps personnel. Why is there such a mistrust of physicians in organized medicine in this country, when it seems to me we have one of the highest systems of patient care in the world?

I don't deny that there are deficiencies, but can the federal government state that their regulated programs have no deficiencies? I read almost weekly in the paper about some bureaucratic botchup, which costs the taxpayers hundreds of millions of dollars. Are these legislators, bureaucrats, and government administrators punished for this waste of our tax money? I think not.

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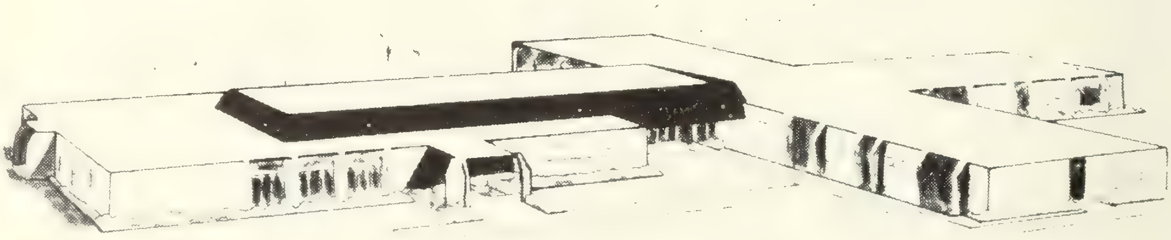

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Family physicians and the year ahead

By George A. Dean, MD
Southfield

(The following is excerpted from Doctor Dean's inaugural address delivered as he was installed in July as president of the Michigan Academy of Family Physicians.)

The comprehensive and multidisciplinary approach is the magic which makes family practice the oldest tradition of medicine and explains its success as American medicines' newest specialty.

During the past seven years, due to the diligence and toil of family practitioners over the length and breadth of this country, we have witnessed the renaissance of family practice. The membership of the American Academy of Family Physicians has grown to 38,000 — making it the second largest medical organization in the United States of America and the largest specialty organization. From 10 family practice residencies in 1970 training 100 residents, we have seen a veritable explosion in 1976 of 280 programs training nearly 4,000 residents. Our goal of 25% of the American graduating medical class entering family practice training programs is within our grasp.

In 1969 there were four departments of family practice in our medical schools. Today there are 90 departments and divisions in the 115 American medical schools. In October of 1976 a unique event will occur when the American Board of Family Practice will hold the first mandatory recertification of a medical specialty in the United States of America. Eighteen hundred of the 9,000 diplomates, including myself, will participate in this medical milestone.

Our successes are many but we must be aware that there are forces which view with disfavor our philosophical approach to the practice of medicine. They have taken a militant stand to sidetrack our prog-

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DOCTOR DEAN/*Continued*

ress and if given a chance would seek to diminish our influence or eradicate our presence. That is why we must rededicate our resolve and heighten our commitment at this critical period in the evolution of family practice.

Let me share with you some of the crucial areas to which we must address our attention and energies during the next year.

1. We must foster our existing family practice residency programs, encourage the development of new ones, with our ultimate goal that of 500 residents enrolled in family practice residencies to meet the needs of family health care in the State of Michigan.

2. Departments of family practice at our universities must be strengthened by the recruitment of practicing family physicians into the academic life to assist our beleaguered professors of family practice.

3. Category I capability must be acquired to insure the quality and success of our continuing medical education program. I am confident that this will be accomplished.

4. Involvement in the Health Systems Agency program is mandatory to cultivate a favorable climate for family physicians to practice in both the urban and rural areas of the State.

5. Inequities in reimbursements to family practitioners must be eradicated to attract bright, young doctors into family practice. Hopefully our grievances will be adjudicated this year.

6. An intensive membership campaign must be launched to recruit medical students, residents and non-affiliated family physicians into association with the Michigan Academy of Family Physicians.

7. We must all support our Second International Medical Seminar to be held in Dubrovnik in October of this year. The scientific program is impressive as to content and speakers.

Doctor Dean

8. Excessive professional liability fees are forcing family physicians to abandon traditional procedures. We must cooperate with the Michigan State Medical Society to overcome this dilemma.

9. We must continue to foster our relationship with the governor's office, the legislature, and the department of public health, all of which have been a vital factor in the success of family practice in the State of Michigan.

10. We must all strive to provide quality care and concerned care for our patients and families, to earn the right to be the center of the health care delivery system in Michigan.

Gathered at a recent MSMS session for county medical society executives were, from left, Carl King, Saginaw County; Norman Anderson, Genesee County, and Louise Moses, Washtenaw County.

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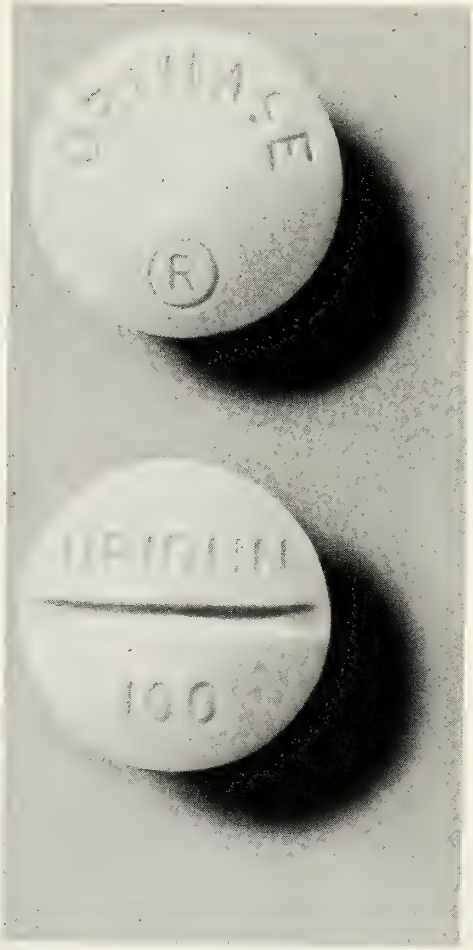
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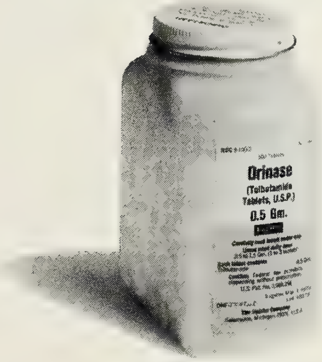
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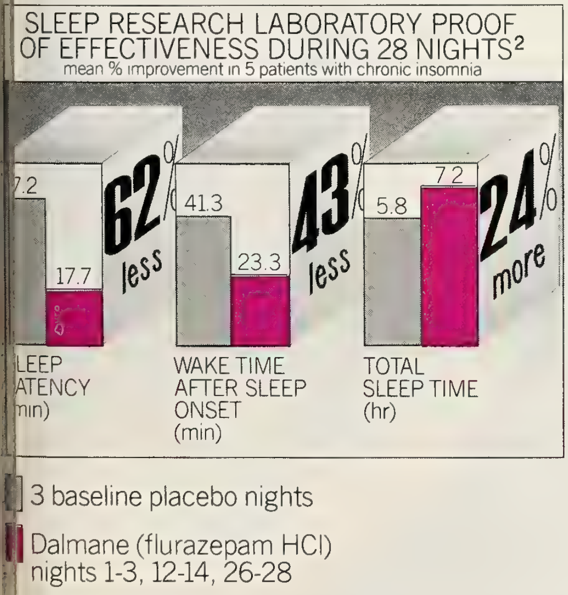

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- ☐ **rapid sleep induction, maintained**
- ☐ **sleep for 7 to 8 hours, on average, maintained**
- ☐ **less time awake during the night, maintained**

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

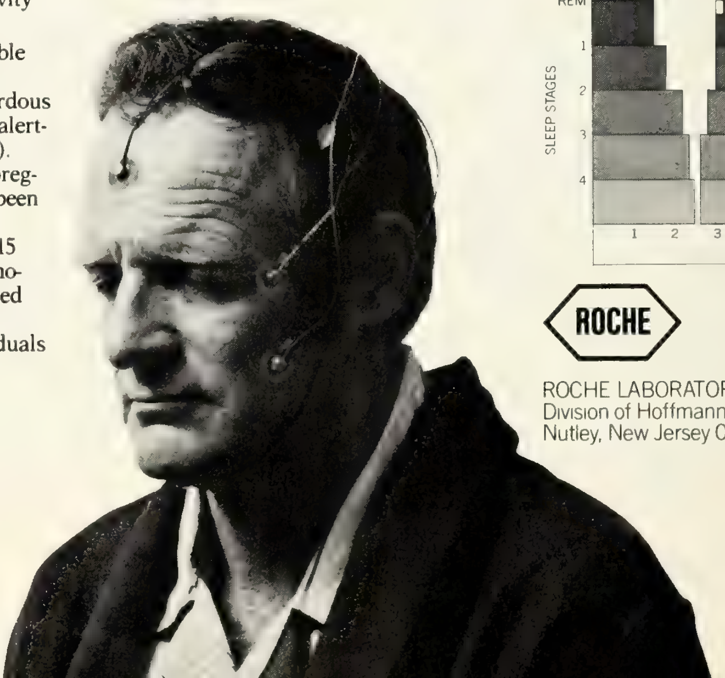
Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatas Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.



Dosage: Individualize for maximum benef effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Kales A, *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975
2. Dement WC, *et al*: Long-term effectiveness of flurazepam 30 mg *h.s.* on chronic insomniacs. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, Jun 30-Jul 4, 1975
3. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
4. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

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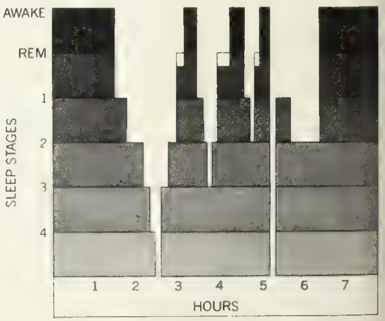

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Heartbeat

By Merwyn Scholten, MSMS Communications Department

Richard A. Antell, MD, Flint internist, has been elected second vice president of the Michigan Heart Association.

* * *

Stuart Bergsma, MD, Grand Rapids, and Harold H. Lampen, MD, Highland Park received their 50-year citations from The University of Chicago Medical Alumni Association earlier this summer. Both graduated from Rush Medical School in 1926. Also receiving a citation was **Everett W. Gaikema, MD, North Muskegon.**

* * *

Robert W. Claytor, MD, Grand Rapids, is Michigan Academy of Family Physicians' "Family Physician of the Year." The 78 year-old black physician was a unanimous selection for the honor which goes each year to a doctor in family practice who best exemplifies the qualities, characteristics and dedication to the ideals of family medicine. Although officially "semi-retired," Doctor Claytor still works half-days in the same office he has occupied for 20 of the 40 years he has practiced in Grand Rapids. Doctor Claytor is credited with opening the door to hospital privileges for black physicians who followed him.

* * *

Wolf Duvernoy, MD, and Boris Silberberg, MD, both of Troy and members of the staff at Providence Hospital, Southfield, are recipients of the Teaching Award of the Year from the Wayne State University School of Medicine. The award is presented annually by first year residents to the physician or physicians who "stand out above the rest as an inspiring teacher." Doctor Duvernoy is a cardiologist and Doctor Silberberg is a pathologist.

* * *

Cecil W. Ely, MD, Saginaw, after 50 years of practice has retired from active office hours. But though he closed his doors at the end of June, Doctor Ely intends to earn the necessary 50 hours of continuing education each year to maintain his medical license. He figures being 75 is no excuse to stop learning.

* * *

Joseph V. Fisher, MD, Associate Professor of Family Practice at the University of South Carolina, and former family physician from Chelsea, recently sent MSMS a copy of the three-part series on "Emotional Illness and The Family Physician" reprinted from Psychosomatics. Doctor Fisher was a collaborator in the study which was conducted among Michigan family doctors by the Michigan Academy of Family Physicians and the psychiatry department of Michigan State University.

* * *

Symond R. Gottlieb, executive director of the Greater Detroit Area Hospital Council, was named recipient of the Joseph R. Homminga Memorial Award presented annually by the Michigan Hospital Association at its summer meeting. Gottlieb is the third person to receive the award and was selected in recognition of his contributions to the hospital and health planning field.

* * *

Thomas Helmrath, MD, Lansing, MSU neonatologist, is an Alfred P. Sloan Fellow by the Massachusetts Institute of Technology. He will participate in a 12-month course leading to a Master of Science in Management degree.

* * *

John F. Konopa, MD, Manistee, recently was honored by the United States Public Health Service of HEW for his 15 years of service as a contract physician for seamen qualifying for care. As contract physician, Doctor Konopa provided outpatient clinic services to seamen coming into Manistee on freighters or as Coast Guardsmen or Great Lakes sailors.

* * *

Paul Lowinger, MD, formerly of Ann Arbor, has left the Prisoner Health Project in San Francisco to assume the post of director of residency training in psychiatry at Highland Hospital in Oakland, California. He has been named an associate clinical professor of psychiatry and community medicine at the U. of California, San Francisco.

* * *

C. Allen Payne, MD, Grand Rapids, past president of MSMS, is currently serving on the national FLEX Board and this year is Chairman of the Day I Committee which oversees the planning and activities related to the first day of the national exam. The first FLEX exam for 1976 was administered in June and the second will be given December 7, 8 & 9, 1976.

* * *

Joseph L. Posch, MD, Detroit, WSU professor of surgery, recently attended the Japanese Society for Surgery of the Hand meeting and presented a paper on "Severe Crush Injuries of the Hand." He reports that there is a very active Charles D. Johnston Surgical Society in Japan composed of men that the late Charles D. Johnston, MD, trained shortly after World War II. All of his former trainees are now professors in their various departments and specialties.

* * *

Francis P. "Dusty" Rhoades, MD, Detroit, is recipient of the Malford W. Thewlis Award for outstanding contributions to the American Geriatrics Society. Doctor Rhoades has served the organization as president in 1972, and chairman of the board in 1973, and is currently assistant vice president in charge of sites and exhibits for the society's annual meeting.

* * *

MEETINGS

September 10-11 — Conference on Arthritis, "Long Term Management" at the Hospitality Inn, Lansing, contact: Mary Flugstad, 23400 Michigan Ave., Dearborn 48124

September 14 — 6th Annual Michigan Heart Association Cardiovascular Research Forum at University of Michigan Medical Science Building, Ann Arbor, contact: Michigan Heart Association, P.O. Box LU-160, Southfield 48076

September 15 — Annual Muskegon Trauma Day, Holiday Inn, Muskegon, contact: G. W. Annessa, MD, 1470 Peck St., Muskegon 49441

September 18 — September Seminar, "Lesions of the Bone," Michigan Society of Pathologists, St. John Hospital, Detroit, contact: Robert Hendrix, MD, Dept. of Pathology, University of Michigan, Ann Arbor 48109

September 24-25 — Regional meeting, White House Conference on Handicapped Individuals, Kalamazoo Center Inn, Kalamazoo, contact: Richard C. Smith, direction, White House Conference on Handicapped Individuals, State Secondary Complex, 7150 Harris Drive, Box 30015, Lansing, 48909.

September 27-Oct. 12 — MSMS/INTRAV trip, Singapore, Bali-Hong Kong Adventure, contact: Marcelyn Ireland, MSMS Headquarters

September 29-Oct. 2 — Conference, Chest Physical Therapy, sponsored by American College of Chest Physicians at Dow Auditorium, Towsley Center, contact: Janet Johnson, Room G2115, Towsley Center, University of Michigan Medical Center, Ann Arbor 48109

October 1-2 — Annual Meeting of Burns Clinic Medical Center at Boyne Highlands Resort, Harbor Springs, contact: Ernest W. Carpenter, MD, Chairman, 560 W. Mitchell, Petoskey 49770

October 1-3 — Michigan Regional Meeting, American College of Physicians, at Otsego Ski Club, Gaylord, contact: Beverly C. Payne, MD, FACP, 425 E. Washington St., Ann Arbor 48108

October 6-9 — Convention, American Medical Writers Association, Pontchartrain Hotel, Detroit, contact: Lillian Lablack, executive director, AMWA, 9650 Rockville Plaza, Bethesda, MD 20014

October 20 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director

October 29-30 — 1976 State Conference of Michigan Association for Children with Learning Disabilities at Hyatt Regency Dearborn, contact: Bea Bury, 2876 Munsfield Ct., Bloomfield Hills 48013

November 6-7 — Conference, "Mind as Healer/Mind as Slayer," sponsored by University of Michigan Extension Service and the Institute of Noetic Sciences in Dearborn, MI, contact: Maurice J. Cameron, 3500 South Thayer, Ann Arbor 48104

December 11 — December Seminar, "Lesions of Salivary Glands," Michigan Society of Pathologists at Rackham Auditorium, University of Michigan, Ann Arbor, contact: John Dunkel, MD, MSU, Department of Pathology, Fee Hall, Room 677, E. Lansing 48824

December 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director

March 30-31, 1977 — Annual Michigan Conference on Maternal and Perinatal Health at Kalamazoo Center Inn, contact: Helen Schulte, MSMS Headquarters

HEARTBEAT/*Continued*

Larry J. Robson, MD, Grand Rapids, is new president of the Kent County Unit of the Michigan Heart Association.

* * *

Yvan Silva, MD, Detroit, may be on the way to a new career as a singer if his recent birthday party is any indication.

A group of friends arranged to take him out to dinner but made a surprise stop at a local recording studio where a group of musicians provided the backup music for five selections which were pressed into an album called "Cuttin' Up." The jacket of the record carries a picture of the popular WSU associate professor of surgery in his surgical garb. J. P. McCarthy, WJR radio's morning personality and a friend of Doctor Silva played one of the selections from the record on his morning show the next day.

* * *

Allison R. VandenBerg, MD, Grand Rapids internist, has given up his private practice of 26 years to become the director of medical services at Mary Free Bed Hospital and Rehabilitation Center this month.

* * *

Charles M. Watts, MD, Ann Arbor specialist in pulmonary diseases at St. Joseph Mercy Hospital, has been named the Harold B and Belle F. Kukes Scholar in Pulmonary Medicine at the hospital.

CORRECTION: Barry G. Smiler, MD, Southfield anesthesiologist, was incorrectly identified as Hugh H. Miley, MD, Birmingham, in a photograph caption in the August issue of *Michigan Medicine*. The photo was part of a feature on the new MSMS Negotiations Division.

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In Memoriam

Charles A. Behney, MD
Tucson

Former Lansing-area obstetrician-gynecologist Charles August Behney, MD, died recently in Tucson, Ariz., at the age of 84. Doctor Behney was former chairman of the MSMS Maternal Mortality Subcommittee. He was graduated from the University of Pennsylvania medical school and was a member of the American Gynecological Society, Philadelphia Obstetrical Society and Michigan Society of Obstetricians and Gynecologists.

Frank L. Harrington, MD
Detroit

Detroit surgeon Frank L. Harrington, MD, died July 15 at the age of 60. Doctor Harrington had been on the Providence Hospital staff for 25 years and had been chief of surgery there. He was a graduate of Wayne State University School of Medicine and was a member of the American College of Surgeons and Detroit Academy of Surgery.

Euclide V. Joinville, MD
Detroit

Past president of the Wayne County Medical Society, Euclide V. Joinville, MD, died July 19 at the age of 92. Doctor Joinville was a graduate of the old Detroit College of Medicine and Surgery and was former chief of staff of the St. Mary's, now Detroit General, hospital. He was a founder of the American Academy of Ophthalmology, and of the Children's Aid Society. He also was a member of the American boards of Laryngology and Ophthalmology.

Eugene J. Keeffe, MD
Birmingham

Former chief of staff of Pontiac's St. Joseph Mercy Hospital, Eugene J. Keeffe, MD, Birmingham, died July 13 at the age of 60. Doctor Keeffe was a Graduate of Louisiana State University medical school and was an assistant professor of clinical radiology at Wayne State University. He was president-elect of the Michigan Radiological Society, a fellow of the American College of Radiology, member of the Radiological Society of North America, the American Roentgen Ray Society, the Eastern Radiological Society. He was chairman of the radiology department at St. Joseph Mercy since 1960.

Duane R. Larkin, MD
Northville

Duane Rhoades Larkin, MD, Detroit-area physician, died July 21 at the age of 53. Doctor Larkin, a graduate of Jefferson Medical College, was affiliated with The Grace Hospital, Detroit. He was a member

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Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the four-week period ending July 30, 1976

	1976 This 4-Week Period	1975 Same 4-Week Period	1976 Total To Above Date	1975 Total Same Date	Total Cases for 1975
Rubella	76	16	1,346	1,374	1,975
Cong. Rubella Syndrome	0	0	0	1	1
Measles	191	68	5,597	2,980	3,253
Whooping Cough	6	1	47	44	98
Diphtheria	0	0	0	1	1
Mumps	68	131	4,791	7,901	9,979
Scarlet Fever & Strep Sore Throat	1,092	817	15,720	15,127	23,777
Tetanus	0	0	0	0	0
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	217	197	1,471	1,630	2,877
Salmonellosis (other than S. typhi)	59	64	468	462	864
Typhoid Fever (S. typhi)	0	2	6	4	10
Shigellosis	49	44	346	421	745
Aseptic Meningitis	14	16	63	63	280
Encephalitis	4	5	41	44	168
Meningococcic Meningitis	4	1	47	56	76
H. Influenza Meningitis	10	8	85	76	142
Tuberculosis	112	97	791	689	1,220
Syphilis	73	147	628	969	1,614
Gonorrhea	2,675	2,373	18,827	17,393	32,472

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

IN MEMORIAM/*Continued*

of the American Academy of Family Physicians.

Miar John McLaughlin, MD
Jackson

Past president of the Jackson County Medical Society, Miar John McLaughlin, MD, died July 6 at the age of 87. He was a graduate of the former Detroit College of Medicine and Surgery and had been affiliated with Foote Memorial and Mercy hospitals in Jackson. A urologist, he was a member of the Detroit Branch, American Urological Society.

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PHYSICIANS WANTED: LaFollette Community Hospital, LaFollette, Tennessee is seeking an emergency room physician for immediate placement. Also, in need of family practice physicians, OB-Gyn and pediatricians. Guaranteed minimum $30,000 per year. Complete furnished office building adjacent to hospital. Located in East Tennessee, 45 miles north of Knoxville. Contact: J. B. Wright, Administrator, LaFollette, Tennessee 37766. Phone (615) 562-2211.

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The community currently has three general practitioners, one of whom is semi-retired, averaging 60 years of age. It has two clinics, a 34-bed hospital, a 60-bed nursing home and two pharmacies.

A surgeon and pathologists from Mankato and a radiologist from Albert Lea make regular trips to the community and hospital. Medical specialists are available at Mankato (35 miles) and Albert Lea (25 miles).

For additional information, contact D. H. Gilbert, Wells Municipal Hospital, 400 - 4th Avenue, S.W., Wells, Minnesota 56097. (507) 553-3111 or 553-5904.

103 acres of land for sale by owner. Adam F. Ponte, D.D.S. Land is located on Merritt Road in Pittsfield Township, Washtenaw County, Michigan, immediately west of U.S. 23. Land is approximately five-eighth mile south of Pittsfield Township's "New Township Center," at Michigan Avenue and Platt Road — where the new fire station stands. Sewers extend along Michigan Avenue to Platt Road, and are projected to come one-half mile South on Platt Road toward property. Offering price: $1,750 per acre. Call (313) 475-9191 or write 220 West Middle Street, Chelsea, Michigan 48118.

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POTPOURRI

By Herbert A. Auer, Executive Editor

David Sanford in his work, "Me and Ralph: Is Nader Unsafe for America?" puts the spotlight on Nader's underside. Sanford contends that Nader and other self-appointed protectors of the common weal often play a role in public decision-making disproportionate to both their actual numbers and the factual content of their arguments. Sanford is critical of Nader for refusing to make public his tax returns, while blasting others for their high income.

* * *

As a Bicentennial question, did you ever hear of Benjamin Harris? He printed the first paper in America in a small shop in Boston. He ran into trouble on his first — and only — issue. Not for printing libels, but for printing the truth . . . and because he did not have the approval of the Crown.

* * *

Ninety percent of smokers have tried to stop smoking or would do so if it were easy, and 61 percent have made at least one serious attempt to stop. Other new figures from the National Clearinghouse for Smoking and Health showed that a smaller percentage of American males smoke now than five years ago. The decrease among women was not quite equal to that among men. The recent surveys found that "attitudes toward smoking are generally growing more negative."

* * *

One of the easiest ways — and most reasonable — to get good daily exercise is rope skipping, according to Joseph Arends, MD, Troy. In a *Detroit News Accent* feature, he explained that 15 minutes of skipping is roughly the same as running two miles.

* * *

Media executives are concerned about public reactions to all the hard-hitting investigative reporting, etc. Harold Anderson, outgoing chairman of ANPA, recently said, "We didn't become journalists to be loved. But if we aren't trusted, we don't have much left." He continued, "The First Amendment would prove too thin a garment if we ever had to try to wrap ourselves in it to withstand the cold wind of a majority opinion convinced that the news media cannot be fair as well as free."

* * *

Here's a novel suggestion by Elmer White, executive director of the Michigan Press Association. He suggests that the Michigan legislature should in odd number years handle appropriation matters and then restrict itself to repealing laws which are on the books — and then in even number years, the legislature should be free to make new laws provided they make no more than had been repealed the year before.

* * *

The Ford Foundation, which helped finance the Drug Abuse Council, makes this evaluation: "Drug abuse remains a persistent problem. Recent federal statistics reveal a massive upsurge in heroin use, demand for treatment has now surpassed capacity, and in some areas of the country waiting lists have re-emerged for the first time since 1972." The Foundation continues, "Furthermore, there is no other private organization on the national level providing information and nonpartisan analysis for long-range policy decisions." The Council will continue its work for the next two and one-half years and the Foundation has made a new grant of $2.4 million.

* * *

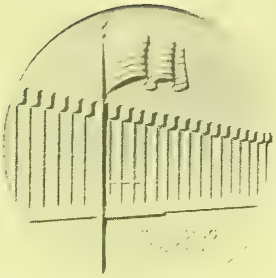
Did you know that a father and son were both presidents of MSMS? C. M. Stockwell, MD, Port Huron, was our first president in 1866 and his son, Charles, was president in 1906. This historical note comes from A. C. Gholz, MD, of Port Huron.

* * *

James Madison once wrote: "Knowledge will forever govern ignorance. And, a people who mean to be their governors, must arm themselves with the power knowledge gives. A popular government without popular information, or the means of acquiring it, is but a prologue to a farce or a tragedy, or perhaps both."

* * *

MSMS Works For Doctors of Medicine And the Public



The Michigan State Medical Society services 8700 doctors and the people of Michigan.

The Society sponsors programs to advance the professional and economic affairs of its members and to provide specific personal services.

The House of Delegates decides policy positions.

The Council, a 27-member board of directors, conducts the continuing business of MSMS at regular meetings.

Recently the Council has sought to strengthen its ties to the components through increased telephone and mail communication. Committees, representing all phases of medicine, have in many cases been restructured into task forces to facilitate study and decision-reaching.

A 10-member MSMS Judicial Commission, elected by MSMS membership, oversees ethical principles within the society.

MSMS programs include continuing medical education, legislative relations, socioeconomics, etc.

Members receive a monthly journal, *Michigan Medicine,* the bimonthly *Medigram* newsletter and other

CURRENT PROGRAMS OF WORK

Following the 1976 meeting of the MSMS House of Delegates, the MSMS Council identified nine major programs of work for the year. These are listed in no particular order of importance:

- To make arbitration work
- To develop new department of negotiations
- To continue solutions to professional liability problems
- To continue continuing medical education accreditation and programming
- To continue legislative activities to accomplish MSMS goals
- To review and prepare for countersuits in professional liability suits
- To monitor expert witnesses in professional liability suits
- To recruit and retain members
- To expand liaison with specialty societies and other medical groups

pertinent publications.

The MSMS headquarters in East Lansing is a distinctive building designed by noted Michigan architect Minoru Yamasaki.

The decisions of MSMS — the one organization representing the state's entire medical profession — influence the entire medical and health industry.

Developing policies on medicine and health

The procedure by which every MSMS member can participate in MSMS policy decisions has been refined over 108 years. It works like this:

1. Each MSMS member has a voice in establishing the policies of the State Medical Society, through the democratic process set up by the Society.

2. Each MSMS member elects delegates to the MSMS House of Delegates. Each member may ask his delegates to introduce a resolution before the House.

3. Delegates are elected by the 56 component county medical societies. Specialty sections and American Student Medical Association chapters at the three state medical schools are represented. Deans of the medical schools who are members of MSMS are also seated delegates.

4. Resolutions are submitted in writing to the House. Each is turned over to an appropriate reference committee, which holds open hearings at which any interested MSMS member may testify. Some resolutions are concentrated within the profession, but many concern both doctors and public.

5. After the hearings, the committee recommends approval, disapproval, or develops an amendment to the resolution. The report then goes to the House for action.

6. The members of the House act on the reports of each reference committee. Many points of view are presented. Sometimes a special committee is established to study the matter further and report alternatives to the next session.

7. The MSMS Council, which serves as a board of directors and meets regularly between annual sessions, is responsible for implementation of resolutions. The Council also introduces resolutions through the immediate past president. Such resolutions follow the same procedure as those submitted by individual delegates.

* * *

Introducing headquarters staff

The MSMS structure of five departments and several adjunct units is guided by Warren F. Tryloff who as "director" is responsible for the operation of the 26-member staff and headquarters.

The Department of Government Relations is crucial to the interests of the physician, working on the issues of professional liability and arbitration, as well as other medical legislation. An independent lobbyist agent, formerly a staff member, also provides legislative liaison.

The Department of CME Programming and Communications seeks to develop and present MSMS Category I programs; and to tell the public the doctors' side of medical issues through the use of various media.

The Department of Delivery of Quality Medical Care deals with peer review systems, health care delivery, CME accreditation, health manpower, and hospital relations.

The Department of Member Services oversees all meetings, assists the many scientific committees, and is responsible for physical arrangements at MSMS programs and workshops.

The Bureau of Economics provides socio-economic data through meaningful studies and surveys.

A new Office of Special Services assists several accounts, including the Medical Auxiliary, the Medical Assistants Society, Michigan Association for Medical Education, the Michigan Society of Anesthesiologists, and the Michigan Psychiatric Society. These specialty services are provided with quality executive secretary services at the lowest possible cost.

* * *

Obtaining economic information

To provide up-to-date socioeconomic data for Michigan physicians, a Bureau of Economic Information was established by the 1970 House of Delegates.

MSMS members receive the results of meaningful studies conducted by the Bureau and are also asked to participate in statewide surveys, such as the recent "Availability of Care" study.

The Bureau of Economics (renamed this year) is working on in-depth programs with new physicians, through a series of practice management seminars. These workshops provide doctors with extensive briefing into the business aspects of running a medical practice in the most effective way. The seminars were initiated in June 1976 and MSMS staff travel to various districts to present them.

Several physicians serve as advisers to the Bureau.

Division of Negotiations. Established in July 1976, this new subdepartment grew out of a mandate given by the 1976 House of Delegates. Skilled negotiating teams of doctors will represent doctors' interests through discussions and negotiations with insurance companies, prepaid plans, hospitals, and government. The service is available to individual doctors upon request.

* * *

Influencing medical care legislation

Efforts of the MSMS to protect and improve medical care in Michigan are as old as the Society itself. Starting immediately after the Civil War, members worked for three years to convince the Legislature to establish a State Board of Health.

Today a full-time staff person and committees on state and federal legislation keep informed about legislation which can affect the medical profession.

The MSMS legislative efforts are based on resolutions adopted by the House of Delegates, directions from The Council and committee advice. MSMS provides expert testimony before various legislative committees on many medical issues.

Besides maintaining daily contact with the legislature, the Department of Government Relations provides staff and counsel for three influential programs:

Doctor-Of-The-Week Program utilizes the talents of individual physicians in lobbying efforts. The physician arrives at the MSMS offices for a briefing on pending legislation. He spends the rest of the week at the Capitol. Other states have followed Michigan's lead in this innovation.

Component societies' meetings with legislators "back home" provide continuing contact between legislators and the physicians in their constituencies. Several component societies, with MSMS support and advice, hold regular sessions with legislators in their home districts. MSMS offers guidance and direction to any component society willing to implement such meetings.

MDPAC (Michigan Doctors Political Action Committee) is a voluntary nonprofit group of physicians, spouses and other interested persons. It functions separately from MSMS as an autonomous organization. On a bipartisan basis, it supports political candidates sensitive to the needs of organized medicine. In addition, it keeps doctors informed of medical-political issues and gives them an avenue for concerted action. MDPAC offers political educational materials and other information to members, and studies candidates willing to acquaint themselves with medicine's positions. It is guided by a 30-member board of directors.

* * *

Working with state, federal agencies

More and more, medical and health programs are being affected by government agencies. Through organized medical groups, physicians can present a united front to legislative and governmental questions. MSMS remains alert to these questions. Every Michigan doctor is aided by MSMS efforts to understand and influence government programs, regulations and proposals.

An MSMS staff specialist maintains liaison with state governmental agencies, informing appropriate MSMS committees about proposed and operative administrative regulations affecting government-funded health programs and the medical career field.

Administrative regulations which necessitate MSMS involvement are brought to the Council for action, upon recommendation by the Committee on State Legislation and Regulation and the Committee on Federal Legislation.

Important liaison is maintained with the Department of Public Health, the State Health Planning Advisory Committee, the Department of Mental Health, the Medical Practice Board, the Office of Health and Medical Affairs, and other state agencies, as well as the Department of Health, Education and Welfare.

The MSMS staff provides a volume of constantly changing information about government which affects the practice of medicine and the delivery of health care.

* * *

Legal opinions

MSMS seeks to legally protect and advance the medical profession through a powerful trio: the staff-manned Department of Government Relations, the physician-oriented Committee on State Legislation and Regulations, and a legal counsel.

Together they cover the broad area of evaluating and suggesting state legislation and protecting the professional welfare of physician members.

The legal counsel and the legislative affairs manager work in concert to check through the hundreds of prospective statutes submitted each year to the Michigan legislature. Bills that need the professional expertise of legal counsel are sent to his Detroit office where he may analyze and/or write possible amendments as needed, in cooperation with MSMS staff members.

The counsel receives a large number of queries for legal advice from individual members and component societies and from hospital administrators. After researching previous court decisions, or studying the request, he answers each letter, with a carbon that goes into the file at MSMS. Thus, an extensive law-oriented view of medical problems over the past 20 years has been collected through this MSMS service.

The most prolific inquiry sources are the MSMS Committee on State Legislation and Regulations, and the doctors and hospital administrators in the smaller communities.

Counsel answers inquiries from physician members and societies on every conceivable health topic including emergency room procedures, physician assistant problems, drug clinics, component society bylaws problems and others.

* * *

Providing continuing medical education

To help all physicians have access to quality continuing medical education programs, the MSMS Council appointed a Committee for Continuing Medical Education Programming and that Committee now develops the Annual Scientific Meeting and oversees all of the MSMS-sponsored conferences and seminars. The name of the MSMS Department of Communications was broadened to include responsibilities for CME programming.

The Department of CME Programming and Communications is working closely with the medical specialty societies, state schools of medicine, and hospitals. It is placing special emphasis on providing Category I programs at the Annual Scientific Meeting or where there is need, such as the Upper Peninsula, to ease doctors' travel burdens.

A continuous survey of needed programs is also being conducted. University of Michigan, Michigan State University and Wayne State University medical schools each have a representative on the CME Committee, and provide many resource speakers.

The ultimate goal of CME is to provide better patient care by offering physicians new information through a series of challenging, effective programs.

The fall Scientific Meeting, held annually for more than a century, features accredited lectures, panels and presentations to cover the interests of every medical specialty.

Conferences such as those on Maternal and Perinatal Health, and the Medical Aspects of Organized Athletics, also draw many interested physicians.

* * *

Communicating with public, profession

The Department of Continuing Medical Education and Communications keeps MSMS members informed of activities of the society. It also seeks to make the public aware of progressive medical thinking.

MSMS members receive *Michigan Medicine*, a monthly publication which switched from scientific articles to a general interest format in 1976 . . . *Medigram*, a capsulized newsletter, is mailed twice each month to members to inform them of late-breaking medical news. Regularly a sheaf of newspaper clippings about medical news is sent to various Michigan leaders in the health professions.

The department also services the news media. News releases are sent regularly to 50 dailies and 300 weeklies. Medical writers call frequently to obtain background information and sources for news and feature stories. News conferences are sometimes called to give the MSMS viewpoint on current topics.

A monthly half-hour show, *Housecall*, on Detroit's Channel 56, is sponsored by MSMS and the three Detroit metropolitan component societies. It features a telephone-question format with three guest physician panelists. Delta College, Channel 19 in Bay City, provides a similar program, sponsored by three area county medical societies, and MSMS hopes for similar ventures.

The department also seeks and fills requests for medical speakers at component and public meetings, cooperates with other MSMS departments in their communication needs, and acts as a clearinghouse for questions that come to the headquarters switchboard.

* * *

Placing new doctors

MSMS continues to cooperate with the Michigan Health Council in its efforts to place physicians in Michigan. In 1975 a record number, 125 doctors were assisted in finding locations in the state, many in rural communities which badly needed medical physicians. By combining resources, MSMS and MHC improve an already effective recruitment and placement program. The goal is to equalize the distribution of physicians, especially those providing primary care, so all citizens are provided professional medical care.

* * *

Working with components

MSMS maintains liaison with Michigan's 56 component county societies. Efforts to encourage and strengthen these contacts are continuous:

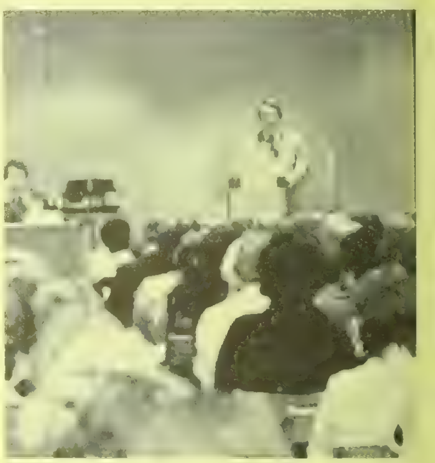
1) Staff members attend county medical society meetings, upon request, to initiate personal contact with officers and members. They present the latest information about MSMS activities and solicit comments of members.

2) The MSMS councilors invite county officers to annual councilor conferences. Delegates, county officers and executive secretaries are able to gain better understanding of the work of their district councilor and the Council as a body.

3) MSMS sponsors Leadership Conferences for leaders of components and specialty societies and regularly sends important reports, notices and publications for their information and consideration.

4) The recently established Department of Member Services installed a small computer to facilitate address printouts and survey research studies. The machine also speeds membership billings and dues collection, and other new projects. The computer service is available to components, specialty groups, hospitals.

* * *



PSRO Support Center

The Michigan PSRO Support Center, based in the MSMS headquarters, is funded by a HEW contract to provide information and technical assistance to requesting physicians, medical groups and allied health personnel. Staff includes a director, associate project director, field representative, and secretary.

The Center sponsors workshops, the most recent in cooperation with the MSMS Ad Hoc Committee on Peer Review Systems. The topic was "Medical Care Evaluation Studies," directed toward physicians, hospital personnel, and other professions that will be involved in monitor and reviewing procedures.

Staff also works directly with requesting physicians on all phases of

PSRO organizational planning, such as bylaws, articles of incorporation, development of contract proposals, recruitment, etc.

* * *

The AMA

The MSMS House of Delegates annually elects representatives from MSMS membership to the AMA House of Delegates, its policy-making body. MSMS delegates introduce resolutions, present Michigan testimony at reference committees, and actively participate in floor debates.

In addition, delegates serve as liaison between AMA and MSMS component societies, appearing as speakers before county medical society meetings and occasionally holding hearings in the state on issues of national importance.

Recently, MSMS was one of six state societies receiving a $25,000 subgrant from AMA to study medical care and health services in county jails.

The master grant, given to AMA by the Law Enforcement Assistance Administration of the Department of Justice, seeks to remedy the serious medical service problems in institutions.

MSMS Department of Delivery of Quality Health Care is overseeing the research being done in four Michigan county jails, representing a range from large (500 prisoners per day) to tiny (6 prisoners per day).

Current research, which is being done with cooperation from the Michigan Department of Corrections, seeks to develop profiles about health care facilities and delivery, general health problems, and costs. Through these studies in six pilot states, AMA hopes to develop a national certification system for penal health services for inmates.

MSMS members are often elected to important policy-developing AMA councils and commissions. MSMS Past-President John J. Coury, MD, Port Huron, is a member of the AMA Board of Trustees.

* * *

Starting a physician-owned insurance co.

In June of 1976 the Michigan Physicians Mutual Liability Company was approved by the Michigan Insurance Bureau. During the previous year, physicians raised the $3,000,000 capital required through the sale of surplus certificates.

Mandated in 1975 by the MSMS House of Delegates, MPMLC offers a practical alternative to the temporary state-sponsored Brown-McNeely Fund.

A nine-person board of directors, elected by the physician policyholders, sets policy for the company. Eight classes of insurance offer well-defined rate structures according to liability risk. Rates have been further categorized according to two geographical regions in which the likelihood of suits varies.

The company, which functions separately from MSMS, is located in East Lansing.

Those wishing to obtain insurance must meet three requirements, (1) be an MSMS member; (2) reside in Michigan; and (3) purchase an MPMLC $2,000 surplus stock certificate.

MPMLC is one of several such non-profit firms launched and supported by state medical societies.

* * *

Aiding students through AMSA

MSMS believes that students' enthusiasm and fresh viewpoints strengthen the medical profession.

Students participate on committees of special interest to them, such as drug dependence, rural health, public relations, maternal welfare. AMSA officers periodically report their activities to MSMS and are asked by *Michigan Medicine* to express their views on contemporary medical issues.

For many years, each of the AMSA chapters has been given a vote in the MSMS House of Delegates.

For many years, MSMS has given financial grants to the American Student Medical Association chapters in Michigan for programs and conferences.

Working closely with AMSA and the Michigan Hospital Association, MSMS has coordinated a program whereby students serve during the summer in community hospitals. Participants, who have completed their freshman year in medical school, serve under a doctor-preceptor and receive a stipend from the hospital.

Legislative efforts to assist medical schools and students continue, of course, in the MSMS department of legislative affairs.

* * *

For the past 111 years, MSMS has been operative in Michigan. Now more than 8700 physicians utilize the services of MSMS in an increasingly complex setting.

A report of the MSMS Council in spring 1976 noted that the preceding year had been "the most critical in the history of MSMS."

"Professional liability insurance availability and cost, continuing medical education, accreditation of programs for CME, cost containment pressures, higher taxes, increasing intervention in medical practice of government by law and regulation, scientific programming, proliferating health planning agencies, higher cost of doing business, are but a few of the problems that your state and county physician leadership are facing," the Council stated.

Constantly changing pressures and attitudes have made MSMS a flexible and modern service organization, seeking to interact with all phases of the medical profession.

One factor remains unchanged however. The decisions of this organization represent the medical doctors of the state, thereby influencing all medical and health care in Michigan.

* * *

Introducing MSMS Director, Managers

MSMS has an experienced, able staff of 26 directed by Warren F. Tryloff, who joined MSMS in 1956. MSMS has four departments and one bureau, each with a manager. Council chairman Ernest P. Griffin, Jr., MD, is responsible for the staff to implement the decisions and activities of the MSMS House of Delegates and the MSMS Council. The last page tells which MSMS members to contact at the MSMS Headquarters for information about the many MSMS activities and the many issues facing physicians and medical organizations.

Warren F. Tryloff

Warren F. Tryloff has been director of the Michigan State Medical Society since 1970. In this capacity he directs the work of the society's 25-member staff.

Mr. Tryloff joined the MSMS staff in 1956 and formerly served as associate public relations director and assistant to the executive director. Before joining MSMS, he was head of the Physician Placement Service of the Michigan Health Council.

He is a former president of the Professional Convention Management Association and a member of the American Society of Association Executives and the American Association of Medical Society Executives. A native of Michigan, Mr. Tryloff attended the Michigan State University School of Business Administration.

Bruce W. Ambrose

Bruce was a reporter and editor on newspapers in Michigan, New York and Ohio for many years before he switched to legislative work.

As chief lobbyist for Michigan doctors, he daily apprises legislators of the medical side of many issues. Since 1970 when he came to MSMS, a new Medical Practice Act has been adopted, the Good Samaritan Act was passed, and the Basic Sciences Act has been repealed.

During 1975, the "year of malpractice crises," Bruce helped influence the passage of fourteen bills to ease the lack of insurance and provide alternatives to courtroom litigation. Before joining MSMS, he worked 10 years as lobbyist for the Michigan Society for Mental Health, and was instrumental in drafting and obtaining passage of the Community Mental Health Services Act of Michigan (1963).

A native of Michigan, he was graduated from Western Michigan University.

John H. Anthony

John came to MSMS in 1971, as director of the newly created Bureau of Economic Information. Since that time, his workload has increased in proportion to the growing amount of socio-economic data that doctors need to work effectively.

As chief researcher of the Bureau, he has conducted and reported several socio-economic surveys.

His articles appear regularly in *Michigan Medicine*. Other major publications include the *Michigan Relative Value Study* and the *Physicians' Fee Study*.

He has served on several health manpower committees and has been adviser to the Michigan Cooperative Health Information System.

Formerly, he was senior financial analyst for William Beaumont Hospital, Royal Oak, where he served as the budget coordinator and conducted fiscal analyses.

John is a graduate of the Wayne State University Graduate School of Business.

Herbert A. Auer

Wayne Burmeister

Richard M. Campau

Herb wears several hats at MSMS. While continuing to work in the areas of communication and publications, his bailiwick for several years, he also has undertaken the task of CME programming.

This new assignment reflects his extensive interest in education. A graduate of Western Michigan University, with an MA in education from MSU, Herb is a former teacher and served five years on the continuing education staff at Michigan State University.

He has kept his interest in education active. An impressive list of former presidencies includes the Adult Education Association of Michigan, Michigan College Public Relations Association, Michigan Jaycees, and Michigan PTA.

As executive editor of *Michigan Medicine* and as PR planner, he can call upon 12 years of newspaper work and five years of PR experiences before joining MSMS.

Before joining the MSMS staff two years ago, Wayne was the AMA Director of Convention Services Department, and was responsible for all AMA meetings and conventions.

A native of Illinois, he was graduated from Bradley University and served as auditor in the U.S. Army.

His first experience with association work was as assistant business manager for the American Dental Association in Chicago, where he was employed for four years.

At MSMS, Wayne supervises many internal functions of the Society. This includes membership records, accounting, meetings, computer utilization, member benefit programs such as group insurance, and building and grounds.

Dick, who holds an MBA from the University of Michigan, has been with MSMS for 16 years.

His duties have included the managing of the Detroit office, where he was responsible for public relations and legislative contact. Previous to that, he was the research director at MSMS, East Lansing. He directed economic research and worked with the Commitee on Legal Affairs, presenting oral and written testimony on medical matters to the state legislature.

In 1965 he was assigned full staff responsibility for all MSMS committees which had economic aspects.

Now, as manager of the Department of Quality Health Care Delivery, established in 1971, he promotes and monitors MSMS involvement in implementing malpractice arbitration, acts as deputy to the Speaker of the House of Delegates, staffs the AMA-funded jail health care project and supervises the PSRO Support Center staff.

Who to Call At MSMS for Assistance

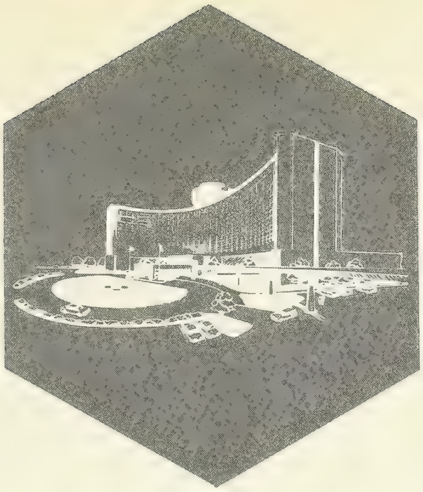
SUBJECT	STAFF MEMBER
AMA Delegation	Warren Tryloff, Vada Davis
AMSA-MECO Project	Jill Kopec
Auto Lease Plan	Wayne Burmeister
Blue Cross/Blue Shield	John Richards
Continuing Medical Education:	
Accreditation	Marce Ireland
Category I Calendar	Marce Ireland
MSMS Programming	Herb Auer
Doctor-Of-The-Week Legislative Project	John Richards
Dues Payments	Bob Roney, Peg Berry
Foreign Medical Graduates	Mert Scholten
Governmental Agencies Liaison	Sherry Wellman
Health Career Recruitment	Sherry Decker
HMOs (Health Maintenance Organizations)	Richard Campau
Impaired Physicians	Vada Davis
Jail Health Project	Richard Campau
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose
Maternal Health:	
Committee	Helen Schulte
Conference	Herb Auer
Medical Assistants	Helen Schulte
Medical Auxiliary	Helen Schulte
Medical Education	Herb Auer
Medical Ethics	Vada Davis
Medigram/Michigan Medicine	Judy Marr
Meeting Information (National, State)	Jill Kopec, Chris Bryant
Member Services	Wayne Burmeister
Membership Records	Peg Berry
Michigan Physicians Mutual Liability Company	Bill Cheeseman (call 351-1150)
Michigan Psychiatric Society	Helen Schulte
Michigan Society of Anesthesiologists	Helen Schulte
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates:	
Agenda and Schedule	Richard Campau
Meeting Arrangements	Wayne Burmeister
MSMS-Sponsored Insurance Programs (Life, Health, etc.)	Bob Roney
MSMS Travel Programs	Marce Ireland
MSMS Media Relations	Mert Scholten
Negotiations	Bill Madigan
Physicians Assistants	Mert Scholten
Professional Liability Insurance:	
Arbitration	Richard Campau
General Information	Bill Madigan
PSRO/Peer Review	Richard Campau
Relative Value Study	John Anthony
Socio-Economic Surveys	John Anthony
Specialty Societies:	
Information	Katie Brewbaker
Council of Specialty Societies	Vada Davis

MSMS PHONE

517/337-1351

MSMS ADDRESS

Michigan State Medical Society
120 West Saginaw
East Lansing, Mi 48823



MSMS Scientific Meeting

Hyatt Regency, Dearborn
Nov. 9-10-11, 1976

MICHIGAN MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 10 OCTOBER 1976

The all-new, Category I — approved MSMS Scientific Meeting is approaching Nov. 9-11 at the Hyatt Regency Dearborn. MSMS members will find registration and housing forms, along with complete program information in the Sept. 17 *Medigram* and September issue of *Michigan Medicine*. In addition, the first October *Medigram* carries names and professional titles of all speakers, along with their subjects. Consult these MSMS publications and then take advantage of this fine continuing medical education opportunity.

Maternal Health Desk Reference Cards #20 and #21, which describe for the physician the most up-to-date information on "important signs and symptoms in the newborn" appear on pages 573-578 inside.

Guidelines for evaluation of Medicaid outpatient clinical records, a long list of coming Category I CME meetings, a feature on the legal services provided by MSMS counsel and news of Michigan doctors' activities are included in this issue.

Does PBB present a hazard to human health in Michigan? With ever more definitive research into the question being initiated in our state, *Michigan Medicine* presents the viewpoints of several scientists and ians on the issue. Check their best advice on 560-570.

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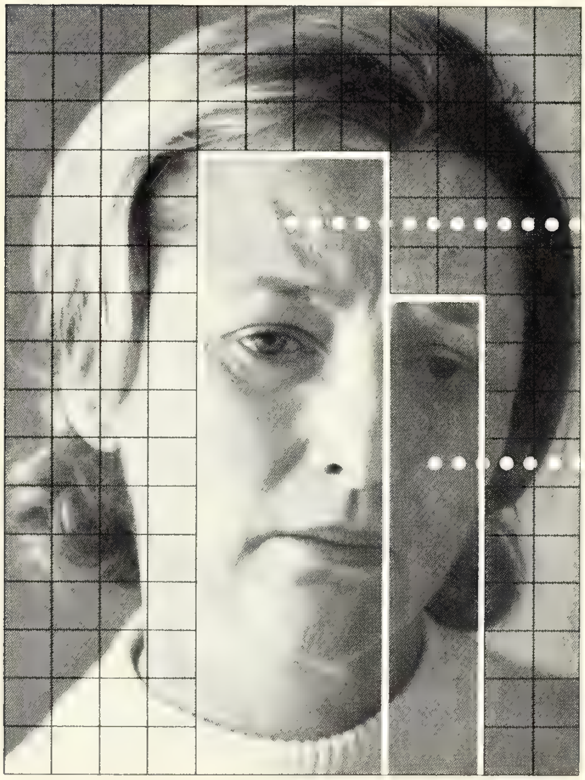
Predominant psychoneurotic anxiety
Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam) Ⓘⓥ

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

contents

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue

Plans are for the November issue of *Michigan Medicine* to present a variety of interesting articles. Among them:

- **Hints for filing your CME reporting form.**
- **The details of Michigan physicians' latest discussions over reimbursement by the Blues.**
- **First in a series on services of the Michigan Department of Public Health.**
- **MSMS Judicial Commission ruling on limited partnerships.**

Michigan Medicine Volume 75, Number 10, October 1976

With concentrations of polybrominated biphenyls (PBB) being found in the tissues of Michigan residents, and nursing mothers concerned whether they should continue to feed their infants and thereby pass on the PBB to their infants, *Michigan Medicine* takes up the debate of the possible health hazards of the chemical. Expert scientists, physicians and government advisors offer their views of this classic example of a toxic substance affecting a captive human population. See pages 560-570.

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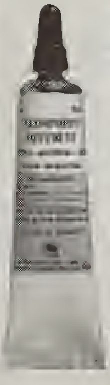

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PRESIDENT'S PAGE

Let's look at total picture of Medicaid abuse

Robert M. Leitch, MD
MSMS President

Many newspapers across Michigan have carried one or more news stories, cartoons, columns and editorials in recent days concerning the frauds, alleged or real, surrounding the Medicaid program.

As MSMS president, I would like to be on record as wholeheartedly against anyone, physician or patient alike, who may be "ripping off" any system.

Several of the columnists have assailed the medical profession for failing to deal with those practitioners who are defrauding the system. Yet, because our professional associations do not license practitioners, there is relatively little we can do.

I hasten to add that less than four percent of the nation's physicians are involved in the alleged ripoffs and in a majority of the proven cases, the physicians involved were not members of their professional association anyway. One columnist recently noted that the 96 percent not involved should be concerned.

WE ARE! MSMS has offered its assistance repeatedly to the State of Michigan. We have offered to act for the Department of Social Services as an audit committee and inspect billings and the actual medical practices of physicians suspected of overbilling or overutilizing Medicaid. We are anxious to eliminate these questionable and costly practices.

I would note that our offers of assistance in this regard have gone unheeded, though I have publicly repeated our offer and included it in a recent letter to 15 of the largest daily newspapers in Michigan.

One must look reasonably at the total picture. Government and consumer abusers must both share part of the blame for the system's seemingly poor performance.

Prior to 1966, most of America's citizens who truly needed medical care were receiving that care by one means or another (and often at no cost to the public since many physicians cared for these people free or at minimal cost.)

But then, as now, there were plenty of politicians who seized upon the issue of health care as one good for maximum political mileage. These politicos, however well-meaning, opened the flood gates for every kind of abuse and fraud known by creating programs which promised free or virtually free medical care to every American needing it.

AN ARTIFICIAL DEMAND was automatically created as every person entitled to the benefits (and a few who weren't) suddenly found himself with a myriad of symptoms demanding the attention of a physician. The result has been an unprecedented demand for services without sufficient availability of suppliers of the services. A rise in the price of the services for all has resulted. And concurrently, a rise in the fraudulent activity occurred.

Despite the overwhelming lack of success of these government programs, we continue to hear our nation's politicians promise nirvana in the form of national health insurance. I trust the thinking citizens of our nation will not be duped into buying these schemes. If they do, I believe I can safely predict the bankruptcy of our nation. America simply cannot afford a system of universal health care that can really produce what glib-tongued politicians say it can.

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New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy,* Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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"We tackle all sorts of problems of interest to all doctors."

That's how MSMS Legal Counsel A. Stewart Kerr describes his work, and it could be his firm's unofficial slogan on behalf of Michigan doctors. For 21 years, the firm now known as Kerr, Wattles and Russell has served the state's MDs collectively.

"During this time we've put together quite an accumulation of briefs, precedents, opinions — it's a roomful, believe me," says Mr. Kerr. He has served as MSMS legal counsel the past 10 years, and was preceded for 11 before that by the late Lester Dodds of the same firm.

Many of the problems MSMS legal counsel tackles for doctors fall into categories, observes Mr. Kerr. These include physicians' relationships with Blue Cross/Blue Shield, procedures for taking care of medical records when a physician retires or changes his practice, doctors' working relationships with hospitals. The firm does a substantial amount of work for out-state hospitals.

Kerr, Wattles and Russell seldom work for individual physicians. But the firm speaks for all physicians as it makes continuing contacts with third party payers, hospitals, health organizations, the legislature, and represents MSMS at hearings.

"One of the most important things we do with the state medical society is to help draft legislation," says Mr. Kerr. The lawyers also gauge the effect of amendments on legislation, advise on the correct semantics and statutory language so that MSMS-proposed legislation says what its proponents want it to say.

A prime example is recent legislation saving health professionals from liability in public health clinics during mass immunizations.

MSMS legal counsel also helped draft one of the best statutes in the country removing from liability physicians who sit on hospital peer review boards.

MSMS departments are in constant communication with the Detroit-based firm of 17 lawyers, 2 paralegal assistants and several clerks. Key persons on the legal firm's staff who work for doctors are Mr. Kerr, Richard Weber, William Sankbeil, and Monte Jahnke. They work hard for MSMS and provide a major benefit to MSMS members.

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Director

MSMS to watch expert witnesses; will you help?

"Suit-alert chairmen" are being named now by component societies at the request of MSMS.

The "suit-alert chairmen" will aid MSMS in meeting one of its major goals for the year, the monitoring of expert witnesses in professional liability litigations.

By doing so, MSMS plans to evaluate and measure the expertise of medical witnesses, and identify the root causes of professional liability litigation. Remedial in-service training programs then can be set up for physicians to lessen the possibility of malpractice disputes.

County medical societies have been asked to designate one physician in each hospital located within their boundaries. That physician will alert the county society about any pending professional liability litigation involving physicians on the hospital staff, and especially about suits going to trial.

The suit-alert chairman is to establish contact with the defendant doctor and attorney to determine who will be MD witnesses for both plaintiff and defendant, and determine when the testimony can be monitored or read.

MSMS has established this work as top priority in response to allegations that often the testimony given by MD witnesses is outside their fields of specialization and of low quality.

MSMS believes expert witness testimony must be of the highest quality if justice is to be served. To the extent that there is any inexpert testimony this project would at least bring it to light and at most tend to diminish it.

Doctor Wilson, at head of table in white shirt, directs a meeting of the program committee and specialty society representatives planning the 1976 MSMS Scientific Meeting.

Robert F. Wilson, MD, leading MSMS Scientific Meeting

By Mert Scholten
MSMS Communications Department

Moving force behind the overall MSMS Scientific Meeting program Nov. 9-11 at the Hyatt Regency Hotel is Robert F. Wilson, MD, a human dynamo in the efforts to coordinate the various activities.

Doctor Wilson is busy overseeing his committee of specialty and sectional representatives in preparing courses and dovetailing a host of related matters.

But being busy seems to agree with the 42-year-old professor of surgery at the Wayne State University School of Medicine who is also the Assistant WSU Dean for Detroit General Hospital Affairs.

As though these academic responsibilities are not enough, Doctor Wilson is also director of the WSU program for thoracic surgery, and is the director of both the shock and intensive care units at Detroit's Harper Hospital.

Born in Scranton, Pa., Doctor Wilson received his BA degree from Lehigh University and his MD degree from Temple University in Philadelphia. He served his internship at Hutzel Hospital and then took residencies in general surgery and thoracic surgery in WSU programs. He also took graduate training in WSU's department of anatomy and at Temple University's department of bronchoesophagology.

Certified in surgery and thoracic surgery, Doctor Wilson is a Fellow in the American College of Surgeons, the American College of Chest Physicians and the American College of Cardiology. He is a member of numerous medical societies, including the Society of Thoracic Surgeons, the American Association for the Surgery of Trauma and the Society for Academic Surgery. He is a founding member of the Society of Critical Care Medicine and serves on the editorial board of the latter's publication.

His scholastic honors include Phi Beta Kappa and Alpha Omega Alpha as well as being named a Markle Scholar in Academic Medicine. To date, his name appears on more than 100 publications, articles, abstracts and papers as author or co-author. Doctor Wilson serves in various capacities on the staffs of 10 different Detroit-area hospitals.

Despite the demands on his time made by all of these activities, Doctor Wilson finds time to pursue a variety of leisure time activities as well. An avid snow skier, he also enjoys water skiing, golf and other athletic pursuits, gardening and landscape work.

He and his wife Jacquelin (who is an RN) also manage to use their northern Michigan cottage as frequently as possible.

1976 RATIO OF POPULATION PER LICENSED PHYSICIAN

(Figures supplied by the Michigan Health Council)

GROUP A. 1 Physician per 189 to 799 Residents

1.	Washtenaw	189
2.	Emmet	251
3.	Grand Traverse	288
4.	Oakland	347
5.	Ingham	455
6.	Kalamazoo	517
7.	Luce	522
8.	Kent	561
9.	Otsego	613
10.	Midland	644
11.	Wayne	682
12.	Wexford	704
13.	Saginaw	711
14.	Genesee	717
15.	Crawford	720
16.	Mason	754
17.	Benzie	781
18.	Marquette	789
19.	Dickinson	792

GROUP B. 1 Physician per 800 to 999 Residents

20.	Manistee	804
21.	Gratiot	818
22.	Calhoun	821
23.	Roscommon	824
24.	Berrien	840
25.	Montcalm	844
26.	Muskegon	846
27.	Macomb	879
28.	Ogemaw	916
29.	Jackson	930
30.	Lake	944
31.	Oscoda	945
32.	Bay	978
33.	Isabella	991

GROUP C. 1 Physician per 1,000 to 1,999 Residents

34.	Lapeer	1006
35.	Alpena	1024
36.	Branch	1024
37.	Huron	1033
38.	St. Clair	1036
39.	Kalkaska	1054
40.	Lenawee	1060
41.	Leelanau	1087
42.	Barry	1090
43.	Charlevoix	1103
44.	Ottawa	1105
45.	Antrim	1147
46.	Iron	1151
47.	Livingston	1156
48.	St. Joseph	1156
49.	Mecosta	1166
50.	Schoolcraft	1175
51.	Chippewa	1200
52.	Mackinac	1208
53.	Cheboygan	1275
54.	Houghton	1283
55.	Delta	1382
56.	Ionia	1389
57.	Newaygo	1400
58.	Shiawassee	1434
59.	Iosco	1465
60.	Van Buren	1478
61.	Osceola	1484
62.	Tuscola	1519
63.	Monroe	1539
64.	Baraga	1558
65.	Oceana	1635
66.	Sanilac	1661
67.	Clare	1670
68.	Alger	1714
69.	Gogebic	1723
70.	Ontonagon	1758
71.	Missaukee	1782
72.	Menominee	1891
73.	Gladwin	1924
74.	Hillsdale	1956
75.	Allegan	1958

GROUP D. 1 Physician per 2,000 to 3,557 Residents

76.	Cass	2166
77.	Arenac	2230
78.	Presque Isle	2567
79.	Montmorency	2624
80.	Eaton	2756
81.	Clinton	2852
82.	Alcona	3557
83.	Keweenaw	*

*No Resident Physician for 2,264 Population

Top Priorities with MSMS

Following the 1975 meeting of the MSMS House of Delegates, the MSMS Council identified nine major programs of work for the year. These are listed in no particular order of importance:

- **To make arbitration work**
- **To develop new department of negotiations**
- **To continue solutions to professional liability problems**
- **To continue continuing medical education accreditation and programming**
- **To continue legislative activities to accomplish MSMS goals**
- **To review and prepare for countersuits in professional liability suits**
- **To monitor expert witnesses in professional liability suits**
- **To recruit and retain members**
- **To expand liaison with specialty societies and other medical groups**

As a result of several meetings, The MSMS Medicaid Liaison Committee has reached agreement with the Michigan Departments of Social Services and Public Health on the appropriate information to be contained in the clinical records for Medicaid patients.

Substantial revisions were accomplished by the Committee in the elimination of non-medical items and clarification on the penalties for non-compliance.

The Committee would like to assure that MSMS members are aware of the record guidelines. The following article outlines the new guidelines for the records.

Guidelines for Evaluation of Outpatient Clinical Records For Clients Participating in the Medicaid Program

In its January 29, 1974 edition of *Medigram,* the Michigan State Medical Society published general guidelines regarding information which physicians should include in the outpatient clinical record for Medicaid clients. In general, it was indicated that the record should include:

1. Identification of the patient.
2. Clinical condition of the patient.
3. Treatment rendered.

The Michigan Departments of Social Services and Public Health interpret these general guidelines to include as a minimum the following:

Patient Identification — Family name, first name, middle initial

Patient's Current (or Usual) Residence — Include zip code (if known)

Date of Birth

Date of Visit

Reason for Visit — The patient's reasons for seeking care, (in his own words, if appropriate)

Findings — A description of the findings revealed by physical examination including Sex and Race ("cauc.," "black," specify other)

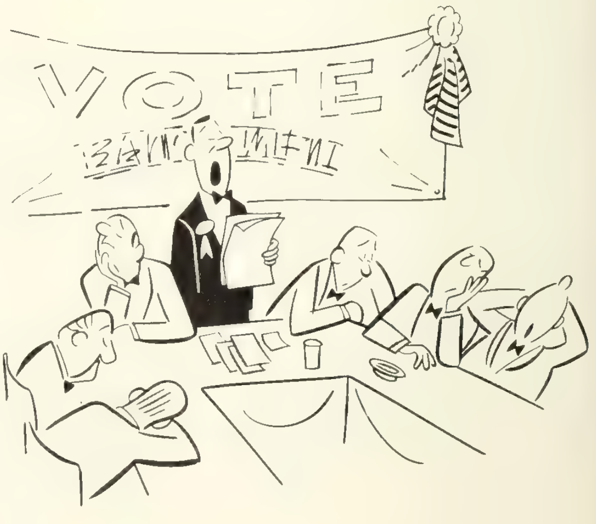
Diagnosis — The physician's current assessment of the patient's problem (confirmed or tentative)

Procedures — Diagnostic, therapeutic and management procedures performed or prescribed during the visit.

Disposition — The next step in the care of the patient.

Provider Identification — In other than solo medical practices, the identity of the physician attending the client should be included in the record entry.

Physicians will be given a warning if the outpatient clinical records for Medicaid clients do not meet the above guidelines. Physicians receiving such a warning will be subsequently reviewed to assure compliance with these guidelines.



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Heartbeat

By Merwyn Scholten
MSMS Communications Department

William G. Birch, Sr., MD, formerly of Kalamazoo and an early Michigan promoter of the physician assistant concept, is recipient of an honorary LLD from Western Michigan University for his assistance and advice. The WMU Student-Physician Assistant Club is named for Doctor Birch who retired to Florida earlier this year.

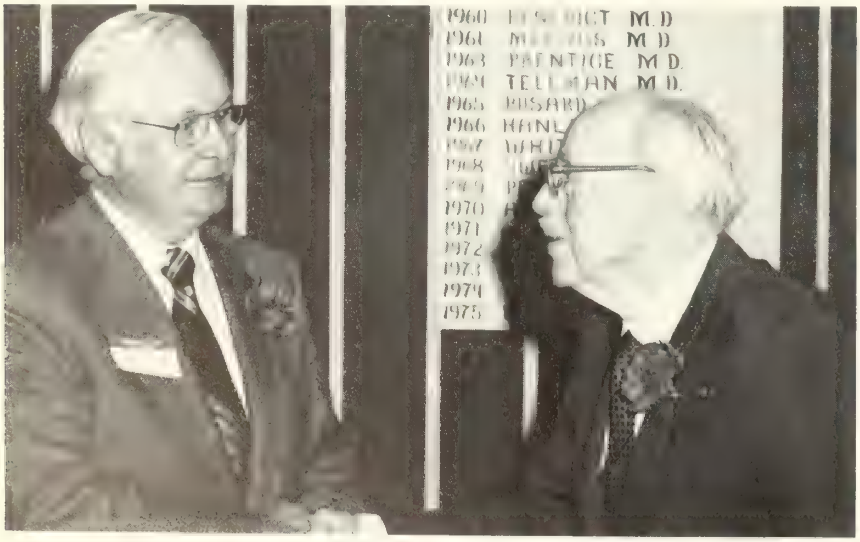
* * *

Vernal Cambridge, MD, Saginaw, is one of six community leaders honored this summer by the Saginaw Club of the National Association of Negro Business and Professional Women's Clubs. Doctor Cambridge was awarded the 1976 Humanitarian Award in recognition of his contributions of self, time and money to many needy people over the years. He has been in Saginaw since 1949.

Thomas M. Flake, MD, Detroit, is new president of the Detroit Surgical Society. A well-known surgeon on the staffs of Hutzel, Harper and Detroit Memorial Hospitals, Doctor Flake is an adjunct associate professor of surgery at WSU Medical School.

* * *

Andrew E. Stefani, MD, Grosse Pointe Woods, is new president of the Wayne State University School of Medicine Alumni Association for 1976-77. A member of the clinical faculty in surgery at the WSU School of Medicine, Doctor Stefani is a 1955 graduate of the school. Doctor Stefani is chief of the plastic surgery section at Mt. Carmel Mercy Hospital and is on the staffs of four Detroit hospitals. He is past president of the Michigan Academy of Plastic and Reconstructive Surgery.



MSMS President Robert M. Leitch, MD, Battle Creek, left, is making an extensive series of visits during his term to county medical societies, describing MSMS programs and goals, and learning of county societies' concerns. One recent visit included the pleasant duty of honoring past presidents of the Muskegon County Medical Society. Receiving recognition at that meeting for being the oldest living MCMS president was C. L. A. Oden, MD, right.

* * *

S. D. Steiner, MD, Detroit, past president of the Michigan Health Council, has retired as medical director after 32 years with General Motors. He is succeeded by Robert G. Wiencek, MD, Detroit, associate medical director since 1973. Rufus W. Miller, MD, Flint, is new associate director and has been with the GM Parts Division in Flint.

* * *

Fred Swartz, MD, Traverse City, was featured recently in the Traverse City *Record-Eagle* in a series of articles on the city's government and how it developed. Doctor Swartz, who came to the city in 1919, is past president of the Chamber of Commerce, served as a city commissioner and later mayor. One of his major accomplishments as mayor was establishing a city charter still in use today. Doctor Swartz retired from Munson Medical Center (which he had helped found) in 1964. Now 89 years young, Doctor Swartz and his wife still reside in Traverse City.

* * *

MICHIGAN AUTHORS . . . Several Michigan doctors have had works published in recent months. **F. M. Davenport, MD, and A. V. Hennessy, MD, Ann Arbor** collaborated with several other authors on "Nonhuman Primate-Associated Viral Hepatitis Type A" published in the Aug. 2 edition of the *Journal of the American Medical Association* . . . **J. F. Greden, MD, Ann Arbor,** published "The Tea Controversy in Colonial America," an account of the ups and downs of tea in America and its medical and political value. *JAMA* carried the article in the July 5 issue . . . **Erwin J. Haas, MD, and Vernon E. Wendt, MD, Grand Rapids,** published a paper entitled "Atypical Measles 14 Years After Immunization" in *JAMA* on Aug. 30 . . . **John H. Tanton, MD, Petoskey,** was the author of a recent *Medical Economics* article, "Get More Out of Giving to Your Favorite Causes." . . . And **Emanuel Tanay, MD, Detroit** wrote an article, "Society is Getting the Doctors It Deserves" which was carried in the June 14 issue of *Medical Economics.*

MEETINGS

(See also listing of Category I programs on page 580.)

October 16 — Seminar on Michigan Occupational Safety and Health Act, for the non-safety professional, Holiday Inn, Southfield, contact: Occupational Safety Associates, 888 National Press Building, Washington, D.C., 20004

October 16-17 — Fall Leadership Training Seminar for Medical Assistants at Holiday Inn, Spring Lake, contact: Helen Schulte, MSMS Headquarters

October 20 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

October 29-30 — 1976 State Conference of Michigan Association for Children with Learning Disabilities, at Hyatt Regency Dearborn, contact: Bea Bury, 2876 Munsfield Ct., Bloomfield Hills 48013

November 6-7 — Conference, "Mind as Healer/Mind as Slayer," sponsored by University of Michigan Extension Service and the Institute of Noetic Sciences in Dearborn, contact: Maurice J. Cameron, 3500 South Thayer, Ann Arbor 48104

November 11 — Executive Committee Meeting, the Detroit Branch of the American Urological Association, Hyatt Regency Dearborn, contact: Guy W. Sewel, MD, 17751 East Warren, Detroit 48224

December 11 — December Seminar, "Lesions of Salivary Glands," Michigan Society of Pathologists, Rackam Auditorium, University of Michigan, Ann Arbor, contact: John Dunkel, MSU, Dept. of Pathology, Fee Hall, Room 677, E. Lansing 48823

December 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

January 19 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

January 23-February 1, 1977 — MSMS/INTRAV Trans-Panama Canal Air/Sea Cruise, contact: Marce Ireland, MSMS Headquarters

February 12, 1977 — February Seminar, "Bleeding Disorders and Thromboembolic Diseases: sponsored by the Michigan Society of Pathologists at Henry Ford Hospital, contact: John F. Dunkel, MD, MSU, Dept. of Pathology, E. Lansing 48823

March 2 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

April 20 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

April 30-May 2— Annual Session, MSMS House of Delegates, Troy Hilton, Troy, contact: Richard Campau, MSMS headquarters.

May 6 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

June 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

August 6-10, 1977 — Annual Convention and Scientific Assembly of the Michigan Academy of Family Physicians at Sugar Loaf Mountain, contact: Charles Schoff, MD, 5209 Sunset Drive, Midland 48640

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the four-week period ending Aug. 27, 1976

	1976 This 4-Week Period	1975 Same 4-Week Period	1976 Total To Above Date	1975 Total Same Date	Total Cases for 1975
Rubella	15	23	1,361	1,397	1,975
Cong. Rubella Syndrome	0	0	0	1	1
Measles	233	25	5,830	3,005	3,253
Whooping Cough	6	4	53	48	98
Diphtheria	0	0	0	1	1
Mumps	34	68	4,825	7,969	9,979
Scarlet Fever & Strep Sore Throat	923	788	16,643	15,915	23,777
Tetanus	1	0	1	0	0
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	200	246	1,671	1,876	2,877
Salmonellosis (other than S. typhi)	112	67	580	529	864
Typhoid Fever (S. typhi)	2	1	8	5	10
Shigellosis	43	54	389	475	745
Aseptic Meningitis	12	16	75	79	280
Encephalitis	10	3	51	47	168
Meningococcic Meningitis	2	2	49	58	76
H. Influenza Meningitis	7	9	92	85	142
Tuberculosis	108	98	899	787	1,220
Syphilis	65	118	693	1,087	1,614
Gonorrhea	3,186	2,653	22,013	20,046	32,472

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

RECENT CHANGES
federal register
highlights
Providing Drug Information to Physicians
Informational Bulletin #433-76
To
Subject
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
D
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all inds of scrutiny. Your control over patient therapy is eing monitored, judged and occasionally abrogated, ometimes by unknown third parties.

The worry is that in the wake of this focus, the relaionship between you and your patient will be weakened, ithout offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, egulations or professional custom stipulate that your on-generic prescriptions be filled with the precise prodcts you prescribe. But in the last five years, a dozen or hore State laws have been changed, permitting the pharhacist in most cases to select a product of the same eneric drug to fill any prescription.

Ironically, this dilution of physician control has aken place against a background of growing evidence hat purportedly equivalent drug products may be inquivalent, since neither present drug standards nor their nforcement are optimal. In fact, the FDA itself says it as not enforced the same standards for hundreds of follow-on" products that it had applied to the original DA approvals. Thus physician control over patient herapy is being eroded with a risk that patients may be xposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced rescription prices for consumers. Yet no documentation f any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is Federal regulation designed to cut the Government's rug bill by setting price ceilings for drugs dispensed to edicare and Medicaid patients. Unless the prescriber ertifies on the prescription that a particular product is hedically necessary, the Government intends to pay only or the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

"I liked the manner . . ."

I liked the manner in which you presented my edited remarks to the Beyer Memorial Hospital in Ypsilanti in the August issue of Michigan Medicine.

Unfortunately your printer misread G. for S. as my middle initial, but errors can be forgiven.

Sincerely yours,
Karl S. Klicka, M.D.
Executive Director
Peoples Community
Hospital Authority

". . . to remind all practitioners"

The State Disability Determination Program under Social Security would like to remind all practitioners in organized medicine of our continuing need for consultant examiners willing to examine a few patients monthly in their offices. Current rates for such examinations will be raised in the very near future. We would like to re-emphasize our urgent need for doctors of all disciplines, especially in the outstate area.

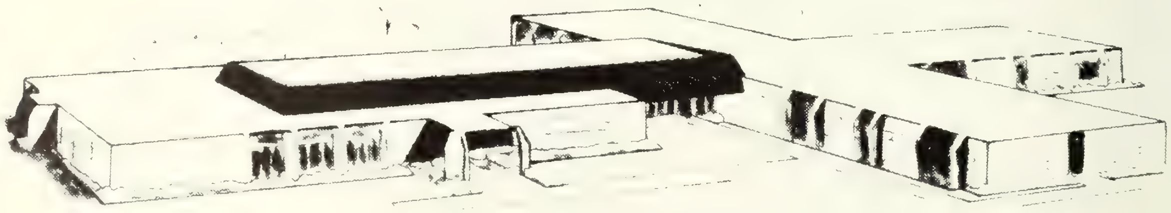
If you are not already examining for our agency, would you please drop me a line or call collect so that I may explain further our need for your help.

David P. Gage, MD
Chief Medical Consultant
Disability Determination Program
Box 30011
Lansing, MI 48909

Privacy of records

Physicians who believe the privacy of their medical records has been violated are invited to contact Alfred M. Freedman, MD, chairman, the National Commission of Health Records, 1700 18th Street, NW, Washington, DC 20009.

FOREST VIEW PSYCHIATRIC HOSPITAL



Jack N. Carr, MD, Medical Director

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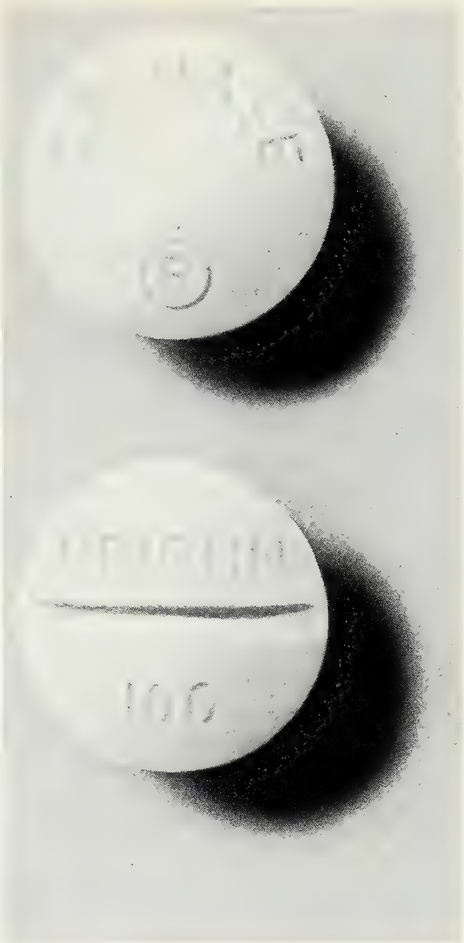

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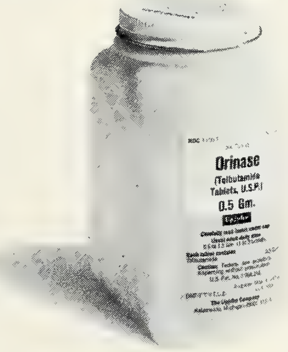

This new design will help pharmacists, physicians, nurses, and patients identify Orinase by name and manufacturer. The number on the tablet is for identification and is not related to tablet strength.

You may wish to advise your patients that this change is taking place.

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Practice Management

Facts You Should Know About Discontinuing Practice

(The following is presented with the approval of MSMS legal counsel.)

Physicians may find it necessary to discontinue their medical practice for any number of reasons such as age, illness, change in specialty, or change in location of practice. When these events occur, and it becomes necessary to notify patients of the physician's discontinuance of practice, the physician must realize that he will not only be closing down an office, disposing of equipment, providing for transfer or storage of records, and other obvious tasks, but he will also be terminating the physician-patient relationship existing between him and all of his patients.

Improper or ineffective termination of this relationship may subject the physician to allegations of abandonment in malpractice cases should the patients not be properly informed of the physician's discontinuance of his medical practice.

Of course, the patient may be notified that the physician's office is closing by the receipt of an actual notice or be adjudged to have received constructive notice, but the physician is well advised to take every reasonable step available to notify his active patients of the following:

1. That he is discontinuing his medical practice on a specific date;
2. That the patient should make arrangements to secure the services of another physician; and
3. That the patient records maintained by the physician *may* be made available to the patient's new physician under certain specific circumstances, though care should be taken that no inference is communicated that the *patient* has a right to physical possession of the records.

While oral notification and public announcement in the newspaper may be properly utilized, *written notice* to each of the physician's active patients should also be made.

In addition, the physician who is discontinuing his medical practice should protect himself by insuring that the medical records transferred will always be available to him should he need such records, or, in the alternative, if the records are to be copied or reproduced, that the cost for such reproduction will be borne by the patient or the new physician, should the physician discontinuing practice wish to make such a charge.

The following letter may be used as a model for physicians who are discontinuing practice.

If a charge is to be made for reproducing the records, the following sentence may be added to the authorization to transfer records:

"I further understand that I will be responsible for the clerical and reproducing costs incurred in the copying and/or transfer of my records to the above named physician, should that physician request such records."

Dear Mr. ________________:

Please be advised that because of ____________________

____
(my retirement, reasons of health, etc.)
I am discontinuing the practice of medicine on ____________, 19 ________. I shall not be able to attend you professionally after that date.

I suggest that you arrange to place yourself under the care of another physician. If you are not acquainted with another physician, I suggest that you contact my office, or Dr. ______________, or the ________________ Medical Society.
(local)

I shall make my records of your case available to the physician you designate. Since the records of your case are confidential, I shall require your written authorization to make them available to another physician. For this reason, I am including at the end of this letter an authorization form. Please complete the form and return it to me.

I am sorry that I cannot continue as your physician. I extend to you my best wishes for your future health and happiness.

Yours very truly

____________________, M.D.

AUTHORIZATION TO TRANSFER RECORDS

Date:________________

To: ______________________________, M.D.

I hereby authorize you to transfer or make available to ________ ______________, M.D., ____________________, all the records and reports relating to my case.

Signed ______________________________

Early detection of hypertension proved valuable in UP

By Mary L. Cretens, MD, Director
Delta-Menominee District Health Department

A hypertension screening program sponsored by the Delta-Menominee District Health Department and the Michigan Department of Public Health was conducted in schools in Delta and Menominee Counties in the past year. The program was done with two objectives in mind: 1) education in the area of blood pressure and hypertension and its control; 2) the detection of hypertension.

The blood pressure screening was done by a licensed practical nurse, and the educational aspects were conducted by a hypertension control coordinator provided through the Michigan Department of Public Health. Guidelines were set up so the referral level would not be excessively high and yet would capture those most likely to have hypertension (i.e. ages 6-10 years with blood pressures over 120/79; ages 11-14 years with blood pressures over 134/89; ages 15-18-and-over with blood pressure over 139/92).

There were 4,469 students screened. Those with blood pressure elevations were rescreened at the school after a rest of 15 to 20 minutes. The pulse was also recorded at the time of the second screening. Those with elevated blood pressures on second screening were referred along with other family members into rescreening clinics held at later dates at the health department.

Final results obtained on completion of rescreening were: 128 with systolic pressures above acceptable limits and 32 with diastolic pressures above acceptable limits. Twenty-five had both systolic and diastolic pressures elevated.

Some points of interest that appeared in this screening program were:

a) Low yield in the 5 to 11 year group (1.3%)

b) Much higher yield in the 12 to 18 year group (6.2%)

c) Of those who screened positive there were other family members with hypertension as found through screening (30.0%)

d) Obesity as a factor (14.8%) in positive screenees.

e) Slightly higher incidence of hypertension in teen-age boys than teen-age girls.

f) Variation in yields of positives according to geographic location. (This was most noticeable in a few rural areas. Factors influencing this difference were not obvious but water supply, type of community and school, similar racial stock could be factors).

g) In the under-11-years group, there were a proportionately greater number of diastolic elevations than in the over 11 year group.

Summary:

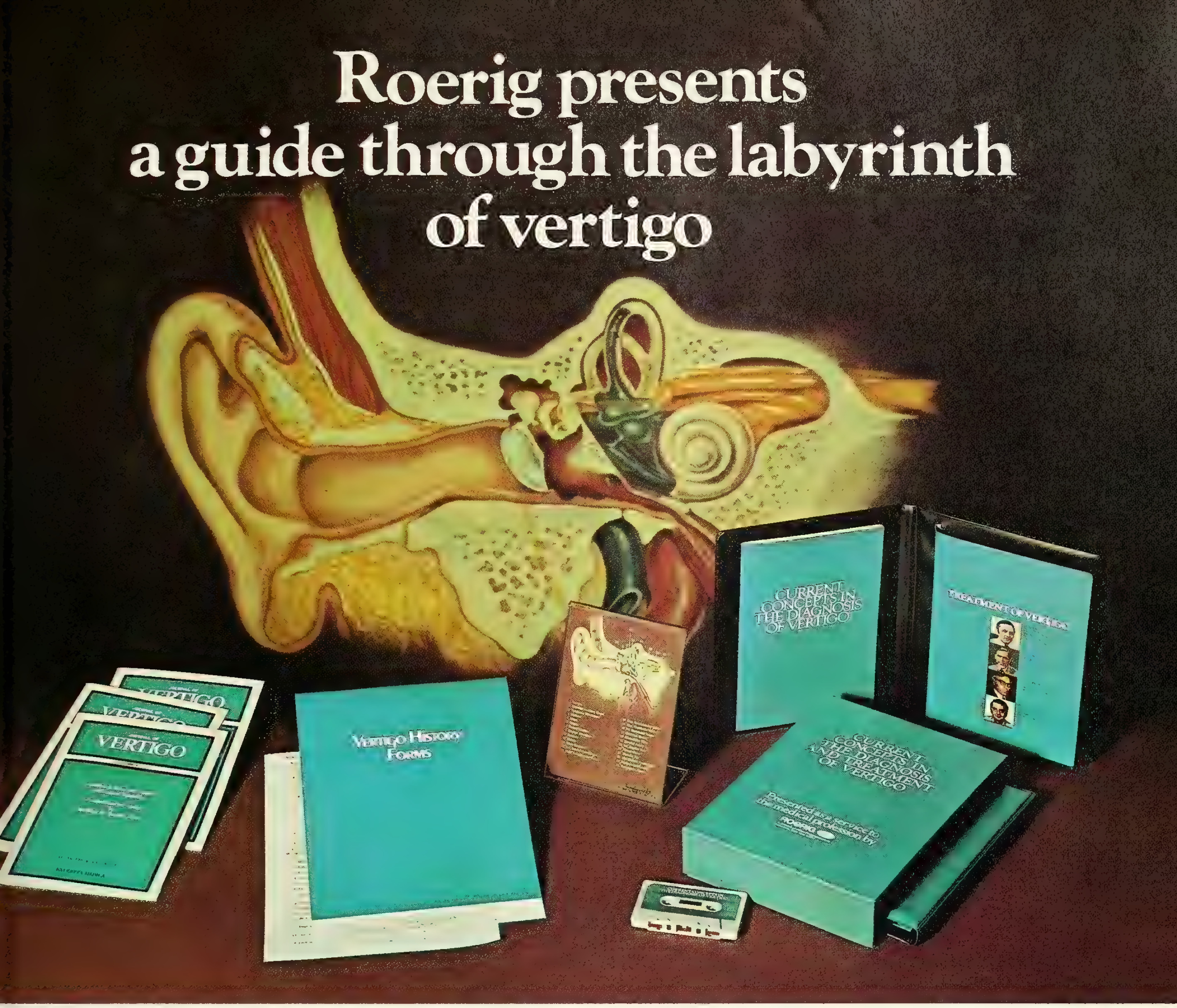
Early detection-type programs such as these are relatively inexpensive and have a moderate yield of persons that do need periodic observation. Positive findings are much greater in the age group 12 years and older. Family history of hypertension has a high correlation, obesity less. Some factors that may increase incidence are unknown. This is indicated by differences in rate of hypertensive children in different areas of the counties.

These federal programs endorsed by AMA

The American Medical Association has endorsed 11 separate federal medical programs and has urged increased funding.

In a statement to the Senate Subcommittee on Health, the AMA said it shared the Administration's concern about the national economy but pointed to "the long-range impacts that a reduction in appropriations for certain programs would have on the health of the population."

The Association recommended more money for: Health Manpower Assistance, The Food and Drug Administration, National Institutes of Health, Emergency Medical Services Programs, Indian Health Programs, Immunization Programs, Venereal Disease Programs, Maternal and Child Health Programs, Alcohol, Drug Abuse and Mental Health, Lead-Based Paint Poisoning Prevention, and Family Planning.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commentary

New bill could burden MDs with Medicaid cost overruns

By John J. Coury, Jr., MD
Port Huron

The AMA Board of Trustees and the House of Delegates have both issued strong critiques of the Tallmadge Medicare-Medicaid Administrative and Reimbursement Reform Act (S. 3205).

The bill sponsored by Senator Tallmadge could have an adverse effect on the delivery and quality of care under those programs, without alleviating the costs.

Doctor Coury

Under the Tallmadge bill, Medicaid fees paid physicians for outpatient care would be not less than 80 percent of "reasonable" charges under Medicare. This may sound attractive, since Medicaid fees in some states presently are as little as 50 percent of the Medicare figure.

But are Medicare charges fair?

And wouldn't the 80 percent figure make doctors continue to bear the onus for Medicaid cost overruns?

The AMA agrees efforts must be made.

Also under the bill, there would be two assistant secretaries of health handling the programs — including a new one to head a Health Care Financing Administration. This would include an Inspector General with authority to review and audit all health programs covered by the Social Security Act.

More bureaucracy would be an expense, without adding appreciably to powers already invested in HEW.

Hospitals all across the country would be classified and categorized, under the Tallmadge bill. Reimbursement patterns for Medicare-Medicaid cases would be geared to the average costs of each class of facility —

Obviously there would be a tendency for hospitals to peg their costs to the average, thus lowering quality.

And besides, hospitals in many states are undergoing fiscal hardships because of present payment levels under Medicare-Medicaid. The Tallmadge bill could squeeze some of them to death.

Doctor Coury is an AMA trustee and past MSMS president.

It's time to crack down on abusers

By James H. Sammons, MD
Chicago

The time has come to crack down — and crack down hard — on Medicaid fraud and abuse.

Responsibility for the sorry state of Medicaid is broadly shared among the administrators of the programs, members of the public Medicaid was designed to help, and the many providers of care — including Medicaid "mill" operators, chiropractors, podiatrists, dentists, pharmacists, optometrists, technicians, laboratory owners and, I am ashamed to say, some members of the medical profession. Unfortunately, we do not have the power to suspend a physician as the bar association can disbar a lawyer.

But the AMA is pledged to take all corrective actions that are appropriate for a professional organization to take. When HEW launched stepped-up investigative programs in Massachusetts and Ohio early this summer we offered our full support, and I will repeat that offer anytime it is needed, anywhere it is needed. A few weeks ago I suggested to Congressman Paul Rogers that he include in the Clinical Laboratory Improvement Act a provision which would order HEW and the Justice Department to file appropriate charges in cases of suspected fraud.

At the AMA annual convention last June physicians went on record condemning acts of fraud, urged government agencies to proceed with speedy prosecution and offered our cooperation and assistance.

Let's not have a witch hunt. But let's have aggressive action. And let those who are guilty of deliberate fraud receive the punishment they deserve, including time in jail.

Doctor Sammons is executive vice president, American Medical Association.

Feature

New bill to treat inebriates could change emergency services

By C. R. Shelton
Special to Michigan Medicine

A new Michigan law, which became mandatory Oct. 1, may have long-range effects on some of the state's emergency care facilities.

PA 339, known as the Substance Abuse Assistance Act, is designed to place incapacitated, public inebriates in treatment centers rather than in jail.

The law defines an incapacitated person as one who, "as a result of the use of alcohol, is unconscious, exhibits other acute medical problems requiring medical assistance, or otherwise has his or her mental or physical functioning so impaired that he or she is likely to cause or suffer physical harm, or to damage property, or is incapable of realizing and making a rational decision with respect to his or her need for treatment."

Treatment, in this case, means "an emergency, outpatient, intermediate or inpatient service and care, and may include but is not limited to diagnostic evaluation, medical, psychiatric, psychological, and social service care, which may be extended to a person who is or appears to be incapacitated."

The Act originally called for all Michigan hospital emergency departments to be a part of the treatment system (the system includes "approved service programs" which are substance abuse treatment-rehabilitation centers licensed by the State) for public inebriates and for them to be treated by physicians. It has since been revised to permit hospitals to negotiate whether they will provide treatment under the Act. Additional revisions state that all services do not necessarily have to be administered by a physician.

Pilot centers open

The State's Office of Substance Abuse Services now has four pilot treatment centers in operation — in Kalamazoo County, western Wayne County, a four-county area in the Thumb, and a multi-county region in northern Lower Michigan.

Even with these, no one knows, as yet, how many hospital emergency departments will be utilized under Act 339 when it becomes fully operational.

According to the Office of Substance Abuse Services, use of emergency departments will vary in different geographic areas. In large, populous areas with good hospital services there may be extensive use of emergency departments. In less populous regions where hospitals are somewhat scarce, detoxification will be handled, for the most part, at approved service programs. In areas where there are no hospitals, there is no choice but for the State to establish approved service programs, if services are to be provided.

The Act has been less than enthusiastically received by many Michigan emergency department physicians. They tend to view the prospect of having officials bring public inebriates in as disrupting to service needed by accident victims and the critically ill.

Robert Rathburn, MD, Flint, president of Genesee County Outpatient Corp., McLaren and St. Joseph Hospitals, and president of the Michigan Chapter of the American College of Emergency Physicians, states that MDs certainly want to take care of ill people, but that public inebriates need further care that can best be provided at special detoxification centers, not in emergency departments.

"This Act looks as if it will be a further misuse of medical talent and dumping of responsibility. It will be a waste of emergency department talent, requiring emergency personnel to act as baby sitters.

"Another serious question it creates is what do emergency departments do with the inebriates after they have been dried out? Often their families have thrown them out and they simply have no place to go."

Inefficient use

Chief of the medical staff at Grayling Mercy Hospital and president of Northern Professional Emergency Physicians, Robert Williams, MD, says that he basically is opposed to the Act because he believes it can cause inefficient use of emergency departments.

"Definitely we must examine everyone brought into the emergency department, and the true alcoholic — with a history of being addicted to alcohol — needs hospitalization in many instances.

"However, typical 'Saturday night drunks', if not injured, are something else. Frequently they are disorderly and are disruptive to emergency departments and hospitals."

G.D. Clark, MD, president of Ingham Emergency Physicians, St. Lawrence Hospital, Lansing, adds that the inebriates in emergency departments are going to cause a lot of trouble.

"They may be unruly patients who take time and personnel away from persons in great need of immediate medical attention.

"As I see it, the best solution to the Act's requirements is for all public inebriates to be 'dried out' in detoxification centers."

Michigan dairy products free of PBB

No Michigan dairy products were found to contain the toxic chemical PBB in tests made in July or August, according to State Agriculture Director B. Dale Ball, who released the information late in August. The chemical did turn up in a few meat samples.

According to Mr. Ball, 233 of 249 beef and pork samples showed no measurable levels of PBB. Nine contained trace levels, four ranged from .02 to .049 parts per million (ppm), one was .06 ppm, one was .15 ppm and one was .2 ppm. All were well below the .3 ppm safety level established by the FDA.

Mr. Ball said recent surveys of poultry flocks have not disclosed any PBB residues in poultry or eggs, and commercial animal feed is completely free of contamination.

Is PBB a human health hazard?

The worry, the discussion and the study continue in Michigan over whether humans are harmed by concentrations of PBB in their body tissues.

This month, medical experts from the Environmental Sciences Laboratory at Mt. Sinai Medical Center in New York will begin the most definitive study to date of Michigan farmers who have been exposed to PBB (polybrominated biphenyl). In 1973, PBB accidentally was mixed in the feed of Michigan farm animals.

This study follows on the heels of continuing reports that PBB in rather high but not yet proscribed, amounts is being found in the breast milk of Michigan mothers not initially exposed to PBB.

1974 cattle burial on state land in Kalkaska County. About 25,000 cattle were buried at this site. Burial was by Michigan Farm Bureau Services, at their expense. These animals had been quarantined for PBB contamination.

Statements have been issued from the Michigan Department of Public Health describing the amounts of PBB found in human milk and advising mothers whether or not to continue or initiate feeding of their infants.

The MDPH earlier conducted tests on the short-term effects of the PBB on exposed Michigan people. The results, which were inconclusive, were reported to a special Michigan Senate Committee, and are discussed in an accompanying article.

All the concern and study have followed the accidental mixing of a fire retardant chemical containing PBB in the feed of Michigan farm animals three years ago. Before the accident was discovered, the meat, milk and eggs of tens of thousands of contaminated farm animals were passed on to Michigan consumers, and the bodies of many animals that had died mysteriously were used in protein supplements fed to livestock.

PBB is a close relative to polychlorinated biphenyl (PCB) an industrial pollutant that, in heavily exposed people, causes liver and thyroid abnormalities, nerve damage, skin lesions and pregnancy problems; and, in laboratory animals, cancer and growth retardation. PBB is stored in the body fat and can be passed on to succeeding generations.

The experts say the conditions in Michigan are almost ideal for studying the effects of an environmental pollutant because PBB was made for a limited time in only one place, and the contamination is still essentially confined to a relatively small area.

Thus, as more definitive study begins on this interesting and ominous human health problem, *Michigan Medicine* initiates its own discussion with the following comments by officials, interested scientists and physicians.

We hope Michigan physicians will find the reading interesting and the information valuable.

Danger not great enough to change FDA's PBB limits

In late June, 1976, the Michigan Agricultural Commission voted not to change the limits for allowable parts per billion of PBB in human food from the amounts already set by the Food and Drug Administration.

The Michigan Governor's Advisory Panel earlier had recommended that the level of parts per billion (ppb) allowed be lowered in the wake of the PBB (polybrominated biphenyl) scare in the state.

"A review of the scientific testimony (presented at the MDA's public hearing June 10 to determine whether the guidelines for PBB should be lowered) reveals it to be predominately in favor of retaining the current guidelines," said Michigan Department of Agriculture Director O. Dale Ball then.

"The accident has already occurred. The major sources of contamination have been located and eliminated. Public health has been protected since PBB was identified in the food chain. Adoption of the panel's recommended levels of 5 ppb for meat and eggs, and 1 ppb for milk is technologically impossible to attain in terms of time and resources.

"Review of the record leads to the conclusion that the preponderance of testimony from scientists with the training, experience and responsibility for protection of the public food supply (and public health) on a state, national and worldwide basis supports the guidelines as presently adopted by the FDA."

Copies of the complete records from the June 10 hearing are available for $40 from the Michigan Department of Agriculture.

Possible effects of PBB on humans

By Larry W. Robertson
Lansing

Gordon Taaffe
Detroit

There is little doubt that Michigan's residents have suffered at least low exposure to PBB and other agricultural and industrial chemicals as well. Non-farm consumers have ingested small quantities of PBB. This has been shown in the results of hundreds of fat and blood samples analyzed for PBB by the Michigan Department of Public Health, as well as samples taken at autopsies.

Whether these small quantities are responsible for illnesses reported by some individuals is a matter of speculation. Certainly some farm families ingested very large quantities of PBB relative to that consumed by the general public.

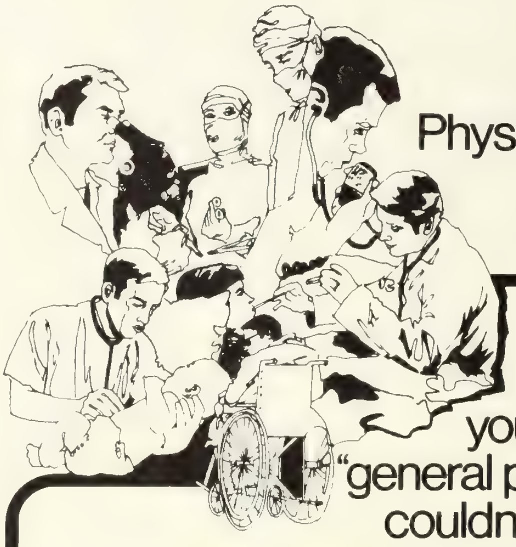
The single most common complaint offered by farmers who were exposed to PBB is that they were tired, slept too long, did not have the energy to do their chores. While some persons have suggested that these symptoms may be psychological resulting from severe disruption of the farmer's primary concern — his livestock — it can also be postulated reasonably that such symptoms are related to a decreased efficiency of energy production at the subcellular level.

In an FDA study, the authors found that "major disruptions in the energy metabolism of the cell are produced by even two weeks of dietary exposure to PCB and PBB. These disruptions were demonstrated both in studies which utilized isolated mitochondria and in studies which measured the *in vivo* concentration of the components of intermediary metabolism . . . Since mitochondria are subcellular organelles which are responsible for virtually all of the energy production of the cell, disruption of this energy production affects all other cellular processes."

What is the fate of PBB once it is ingested? With the exception of lactating mammals and egg-laying poultry, PBB has not been shown to be excreted to any appreciable extent. Apparently PBB finds its way into various tissues, especially adipose tissue and liver. (It does not penetrate the blood-brain barrier.) It may be that PBB chemically modified by the liver or not, is A) not able to be secreted or B) is secreted with bile into the small intestine where it is reabsorbed.

Another common complaint of persons who were exposed to PBB is stomach pain. R.W. Deatrick, MD, of Pickford is quoted in an Associated Press article as observing a twofold increase of duodenal or stomach ulcers among adolescents and young adults in his area. The irritating ef-

(Continued on page 566)



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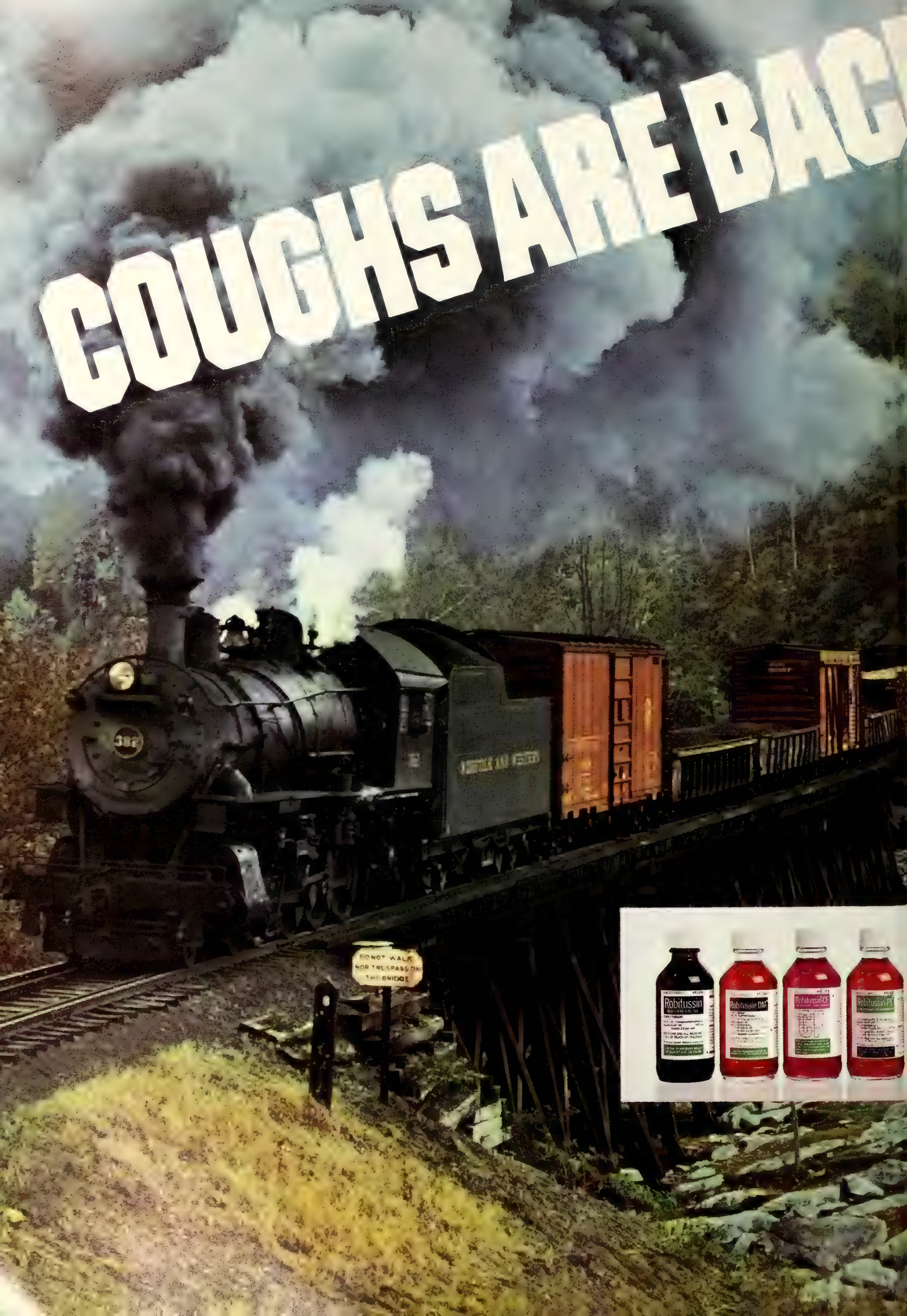
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OUR PHOTO: Norfolk & Western Branch Train No. 202 west bound near Alvarado, Va. (Oct., 1956). This line reaches the highest point of any railroad East of the Rockies (elevation 3,577 ft.) with a minimum grade of 3%. It crosses 108 bridges, some 700 ft. long! Photo by O. Winston Link.

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For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4,
A. H. Robins Company,
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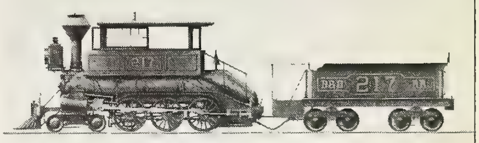
Richmond, Va. 23220.



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PBB/*Continued*

We must protect consumers from toxic chemical contaminants

By Bert N. La Du, Jr., MD, PhD
Ann Arbor

There is no question that many industrial chemicals contaminate our food and cause adverse effects on our health today. Among these chemicals, the polyhalogenated biphenyls (PCB and PBB), are of special concern; they are stable, fat-soluble compounds, taken up and transferred into our fatty tissues, and they remain there for months, possibly for years. The accumulation and slow release from tissue stores represents a special kind of long-term exposure that cancer experts are worried about. More is currently known about PCB than PBB, but there is sufficient experimental evidence in animals to presume that polyhalogenated biphenyls are "weak carcinogens." Individuals with appreciable tissue stores of these chemicals run some increased risk, over the years, of developing cancer.

The degree of risk of cancer from these chemicals is impossible to estimate at this time; we do not have precise methods to quantitate risk from weak carcinogens at present (such as equivalence to smoking so many cigarettes per day), and it will take many years to evaluate the long-term effects of these agents in epidemiological studies. Possibly there is a "safe" level, below which there is essentially no increased risk; but experts can only make an educated guess about a "safe" level for the polyhalogenated biphenyls at this time.

Consumer protection requires that we use every means possible to reduce food contamination by these chemicals and prevent recycling of these materials. Fortunately, plants do not take up PCB or PBB from the soil; fish, however, extract them from our contaminated streams and lakes. Dairy products and meat are potential sources, and these products must also be analyzed by sensitive chemical methods to assure their safety. The unfortunate PBB episode was at least a limited and controllable type of exposure; it was easier to eliminate than the many sources and uses of PCB.

It should be noted that the scientists who are most knowledgeable about cancer from environmental chemicals are the strongest consumer advocates and the most conservative about permitted levels of polyhalogenated biphenyls in the food. Despite the enormous economic consequences, their recommendations are the best we have and must be given serious consideration if we wish to protect the public from toxic chemical contaminants in our food.

Dr. La Du is professor and chairman, Department of Pharmacology, The University of Michigan.

ROBERTSON AND TAAFFE/*Continued*

fects of PCB on the gastric mucosa are well known and one might guess that PBB would have a similar effect, producing pain and affecting the normal absorption of nutrients.

Much attention has been given to the idea of possible thyroid involvement in the herd health problems which exist in Michigan. In one study researchers have noted thyroid hyperplasia associated with octabromobiphenyl exposure. Another researcher has postulated that the structural similarities which exist between triiodothyronine (T3), thyroxine (T4) and halogenated biphenyls may influence the regulation of T3 and T4.

It is interesting to note that diminished serum vitamin A levels have been associated with exposure to chlorinated naphthalenes, polychlorinated biphenyl, and polybrominated biphenyl. It has also been found that liver levels of vitamin A are diminished in monkeys exposed to PCB. Apparently liver tissues respond to certain halogenated hydrocarbons by displaying one or more of the following characteristics relative to vitamin A: a) rate of excretion of vitamin A is enhanced; b) storage sites of vitamin A are interfered with; and c) activation of vitamin A is blocked.

The above speculations are intended to generate discussion among the physicians of Michigan and to create an awareness of potential dangers and possible symptoms which may be associated with low level exposure to persistent industrial and agricultural chemicals.

Doctor Bernstein

Governor's panel recommends surveillance of exposed persons

By I. A. Bernstein, PhD Ann Arbor

The Governor's Scientific Advisory Panel on PBB, of which I was chairman, intensively reviewed the available literature as well as oral and written communications dealing with clinical and scientific data relevant to Michigan's problem with PBB. On May 24, 1976 the panel informed William B. Milliken, Governor of the State of Michigan, that a) "no specific disease or symptomatology in animals or man can presently be associated with exposure to *low levels* of PBB"; b) "administration of *high doses* of PBB to cattle, chickens and rodents however, have produced loss of appetite, inhibition of growth, fetal death and abortion, abnormal cardiac and respiratory function, lacrimation, salivation, severe debilitation, renal, hepatic and cutaneous lesions, teratogenicity, carcinogenicity and death"; c) "*low levels* of PBB in human tissues may, as they do in animals, increase the activity of the metabolic systems responsible for the biological breakdown of drugs," and d) *PBB is a possible carcinogen* on the basis of its similarity to PCB (polychorinated biphenyl) which, at *high dosages,* had "been shown to have resulted in hepatic cancer" in animals.

More recently, a medical report has claimed a relationship between industrial exposure to PCB and the appearance of human melanoma approximately two decades later. The Panel did note the possibility that "a contaminant in the commercial mixture rather than PBB itself" might have been "responsible for one or more of the symptoms recorded" in animals.

Other factors which were considered relevant by the Panel were the following: a) PCB and PBB have similar acute effects on the physiology of animals, but sensitivity to both depends on species and stage of development, newborn animals being possibly more sensitive than adults; b) PBB given to animals is distributed throughout the fat components of most tissues and persists for a long time, and c) a major route of decreasing the body burden of PBB is via mother's milk.

In the view of the Panel, the potential for carcinogenicity and teratogenicity from PBB, the tendency of the body to accumulate and retain the material and the ability of the compound to influence drug and steroid metabolism, argue for protecting individuals from any increase in body burden and for clinically observing individuals with significant levels of PBB in their fat depots.

Doctor Bernstein is professor of biological chemistry and of environmental and industrial health with the University of Michigan School of Public Health.

Health Department doubts PBB causes acute illness

By John L. Isbister, MD Lansing

During the period from April 1973, when polybrominated biphenyl (PBB) was accidentally substituted for magnesium oxide in a supplemental feed for livestock, until the late summer of 1974, when the resultant contaminated beef, dairy products, poultry and eggs were virtually eliminated from the retail markets, a significant proportion of the Michigan population was exposed to this chemical by consuming these products. The degree of exposure was, of course, greatest in those families living on farms where the contaminated feed was used and drinking the milk and eating the meat and eggs which they produced. Probably the next highest exposed individuals were those members of families which, as more or less a routine practice, obtained meat and dairy products from farms where the PBB contaminated livestock feed supplement was used.

Upon discovery of the PBB contamination accident and the proba-

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Doctor Isbister is Disease Control Officer for the Michigan Department of Public Health.

Doctor Isbister

bility that it had produced a wide impact on the human food sources, the immediate concern was the effect this was having, if any, upon the health of exposed humans.

In June 1974, the State Health Department obtained blood specimens and illness histories on 217 members of families consuming meat, eggs and dairy products from farms which had been quarantined by the Department of Agriculture because of PBB contamination. The histories inquired into the occurrence of illness episodes from 1972 — before the PBB contamination occurred — through the date of the interview. Blood specimens were analyzed for PBB and were processed through SMA-12. The health interviews did not indicate any problem patterns or any form of complaint which suggested a pathological situation. The PBB analyses demonstrated the presence of the chemical in the blood. Cell counts and blood chemistries were within normal limits.

None seriously ill

In short, so far as this superficial look was concerned, relatively highly exposed individuals did not seem to be seriously ill and dying as a result of PBB.

This having been established, a more deliberate study was implemented, directed to approximately 290 farm family individuals. This group varied in age from the very young to the elderly and from no known exposure to significant exposure. In addition to a detailed history, with special provision for children, a physical examination was carried out and a blood specimen obtained for PBB analysis.

Since PBB was a new chemical, the effect of which on the physiologic processes of man and animals was completely unknown, a question existed as to what form of pathology should be looked for if this chemical were toxic at the levels observed in humans. The closest similar situation, chemically, was the Yusho incident in Japan where a relatively large number of individuals ingested rice oil contaminated with polychlor-

(Continued on page 570)

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PBB/*Continued*

inated biphenyl (PCB). Recognizing the limitations in this technique, but having nothing better, it was decided that the clinical evaluation of the PBB study subjects would pay particular attention to the symptoms observed in Yusho: Chloracne, problems with vision, problems with gait, weakness, loss of appetite, peripheral neuropathy and liver disease.

In the study group, PBB blood analyses ranged from none detectable (working to a level as low as .003 ppm) to as high as 2.5 ppm. Physical examinations were essentially negative except for a few conditions for which the cause was known. The histories varied from apparently completely good health to complaints of headache, fatigue, loss of appetite, nausea and menstrual difficulties.

Evaluation of the data from this study has failed to indicate a pattern of illness, a symptom complex or a syndrome which can be attributed to the presence of PBB. There was no statistically significant difference in the frequency of these somewhat nondescript symptoms between those with relatively high levels of PBB and those with moderate or non-detectable levels in the blood. Evidence of a dose relationship was non-existent. The study group included several women who completed gestation while carrying a body burden of PBB and additional instances, outside the study group, have subsequently been called to our attention. In no instance was teratogenicity noted and, to our knowledge, there has been no problem with the growth and development of these infants to date. Cord bloods and placental tissue from these pregnancies demonstrated the presence of PBB and it can be assumed that the infant was exposed in utero and carried a body burden of the chemical at birth. Breast milk was demonstrated to contain PBB.

PBB remarkably insoluble

PBB is remarkably insoluble in water and highly soluble in fat. The body burden is carried in the adipose tissue and the amount of the chemical carried in any other body tissue or fluid will be proportional to fat content. Through the analysis of simultaneous blood and fat specimens submitted to the Department of Public Health Laboratories by interested physicians and their patients, it appears that the adipose to blood ratio of PBB is of the order of 200-400 to 1 and the breast milk to blood ratio is 100-300 to 1.

Since little is known concerning the metabolism of PBB by the body, estimates of the time during which it will persist are entirely speculative although a few sequential determinations on a limited number of individuals suggest a long half-life. Evaluation in cows and, to a much more limited extent, in women suggests that lactation does little to reduce the body burden.

Based on the work of the Department of Public Health and several physicians with an interest in this question, it appears doubtful that PBB causes acute illness in humans at the levels observed. Whether or not chronic illness will result from the continued presence of this chemical in the body will have to await the outcome of studies presently underway or planned for the future. Probably of primary interest will be observance for endocrine and hormonal disturbances, developmental problems in children, genetic effects, metabolic problems and carcinogenesis.

The PBB incident in Michigan appears to be unique and, if the proper epidemiologic and special studies can be carried out, should provide a wealth of knowledge possibly applicable to the general question of chemical contamination of the environment and its possible effects on human health.

Physicians may advertise, but not solicit patients

The Principles of Medical Ethics of the American Medical Association do *not* prohibit advertising by physicians, reminds a statement in the May 24 issue of the Journal of the American Medical Association.

In reaffirming the long-standing AMA policy on advertising by medical doctors, the AMA's Judicial Council pointed out that the prescription is not against advertising, but concerns soliciting of patients.

The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and "other useful information that will enable people to make a more informed choice of physician," the AMA Council points out.

"The physician may furnish this information through the accepted local media of advertising or communication, which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings, and reputable directories are examples of acceptable media for making information available to the public.

In the proscribed area of solicitation of patients, the Council points out that it is unethical to use testimonials, create inflated or unjustified expectations of favorable results, make statements that are self-laudatory and imply that the physician has skills superior to others.

Doctor Lightbody "rants and raves" in delightful new book

By Herbert A. Auer
Executive Editor

MSMS Past President James J. Lightbody, MD, Detroit, will gladly autograph his book, "Rant and Rave" for you and surely make some small joke with a glint in his eyes.

"Rant and Rave," published by Harlo Press of Detroit is a collection of articles that Doctor Lightbody wrote for the *Detroit Medical News* over a 10-year period. Before becoming the MSMS president in 1969 he was speaker of the MSMS House of Delegates for nine years, and president of the Wayne County Medical Society.

The author always has had the ability to poke fun at medical societies. In one article about a boring meeting, he observes "when better snores are snored, the WCMS will make them." He advocated a "Committee on Prodding." He smiles while reading an invitation to a MSMS dinner dance that says in parentheses, "dress optional." And in another article he watches an officer preside by deftly using his own "Robert's Rules of Disorder."

Another time he reported about the purchase of a new rug for the room where the Ethics Committee meets. "There apparently have been so many members summoned 'on the carpet' that the darn thing got all worn out."

And once he reported the medical society had for dessert three kinds of cake — chocolate, vanilla and stomach.

"At a recent medical meeting there were two speakers, a psychiatrist and proctologist." The program was entitled, "Odds and Ends."

WCMS and MSMS

After Doctor Lightbody writes with pride about MSMS and WCMS, in his article, "Bouquets," he observes that MSMS and WCMS "are known as rugged individualists with both dogs planted stubbornly on terra firma. We have been credited with holding a high priority on common sense."

Doctor Lightbody dedicated his book "to the doctors of medicine of the Wayne County Medical Society and the Michigan State Medical Society, and the Michigan Arthritis Foundation." He was medical director of MAF for 20 years and widely known as a specialist in rheumatology.

Many articles comment on matters of government. In one article about chiropractors, Doctor Lightbody bemoans the quasi-professional infiltrations to the state legislature and contends, "It shouldn't be necessary to sustain a lobby in Lansing to influence legislators to maintain high health standards."

When complaining about the inroads made by government reports, he says confidentiality is eroding. "It's like having a physical examination on the City Hall steps at high noon."

In talking about political parties, Doctor Lightbody said, "a mugwump is a fellow that has his mug on one side of the fence and his wump on the other."

Many times Doctor Lightbody observes life in Detroit, Michigan and the USA:

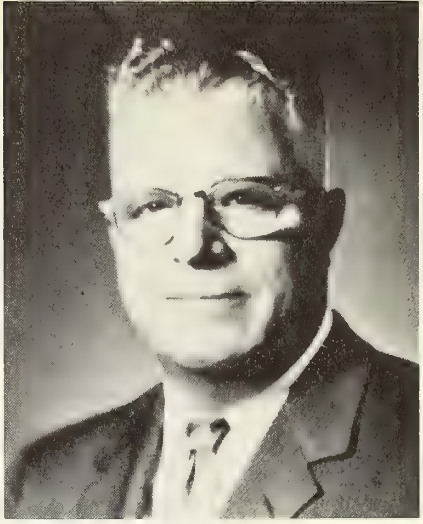
"The Police Department is getting pretty tough on those hit-and-run drivers."

"Those good old days are past when Uncle Sam lived within his income and without most of ours."

Doctor Lightbody has the ability to size up people and situations. He talks about "detail men who frequent our offices, read our magazines, and make dates with our receptionists." He reported that "National Allergy Week is just around the corner and that is nothing to be sneezed at."

Doctors who recall reading the original articles will wonder again where Doctor Lightbody got the jokes he used to pass off as someone else's. Such as:

A feller called and said, "Hey, Doc, what do you advise for my wife's sore feet?" The Doc said, "Rubber heels." The man asked, "with what."


Doctor Lightbody

Or the time he reported about the intern who said to the surgical resident in the operating room, "may I cut in?"

Some of his articles reacted to medical articles he had read in "Reader's Indigestion."

A favorite

One of Doctor Lightbody's short pieces that is my favorite tells about a resolution introduced at a medical meeting:

"Mr. Speaker:

"WHEREAS, there are usually too many whereases in all resolutions, and

"WHEREAS, the word whereas, is considerably abused at all conventions, and

"WHEREAS, the delegates are usually asleep while the whereas part of the resolution is being read, and

"WHEREAS, the continuous repetition of the word whereas is not good style, and

"WHEREAS, there are always more whereases than there are wheres, therefore, be it

"RESOLVED, that a committee be appointed by the Chair to study the Whereas problems; this committee to be called 'The Commission on Whereases' — this Commission to report back to the Council and the House of Delegates and to Local 154 at their earliest convenience."

(NOTE: To order copies of Rant and Rave, send check for $9.25 to Harlo Press, 16721 Hamilton, Detroit, MI 48203).

AMA Commission studying health care costs

(Special from the AMA)

As representatives of the Medical profession, we are all concerned over the rising costs of health care. Recognizing the Association's responsibility for taking a role of leadership in studying these problems and taking action toward their solution, the AMA Board of Trustees has authorized the formation of a National Commission on the Cost of Medical Care. The 27 members are drawn from such diverse areas as: suppliers of hospital and medical care; insurers; government, labor, and consumer representatives; economists; and other allied areas.

The Commission life will be approximately 18 months, and its membership is charged with providing:

- A description of the health care delivery system;
- Identification of the factors underlying the rising costs of medical care;
- A review and evaluation of existing research on the causes of medical care cost inflation;
- An evaluation of the impact of pending or future health care programs on the health care delivery system and medical care costs;
- Recommendations on policies that will contribute to containment of medical costs while providing quality medical care to the public; and
- Recommendations and directions for future research programs.

The bulk of the Commission's findings will be released at the conclusion of its series of general and task force meetings. At that time, final publications will be prepared and printed.

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MATERNAL HEALTH DESK REFERENCE CARD NO. 20

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society)

IMPORTANT NEWBORN SIGNS AND SYMPTOMS IN THE DELIVERY ROOM

(Also see Card #21 *"IMPORTANT SIGNS AND SYMPTOMS OF THE NEWBORN"*

The following information and charts are presented as a helpful and a quick reference guide for all in the delivery room to help them quickly spot actual or potential problems with the newborn. *This is not meant to be complete.* Rather, it is hoped these charts will serve as an adjunct tool to facilitate optimal care for the newborn infant. That is, full evaluation of the risks involved and complete assessment of the infant's condition may lead to earliest consideration of consultation and use of facilities (such as NICU) as indicated.

This information is divided into two parts. Card #20 is a consideration of the Apgar scoring system. This may be used to best advantage in the delivery room. Card #21 concerns particular signs and symptoms of the newborn infant. This may be used either in the delivery room along with Card #20 or it may be used alone in the newborn nursery.

I. The Apgar Technique of Scoring

Sign	0	1	2	one minute	five minutes
Heart rate	absent	slow (below 100)	over 100		
Respiratory Effort	absent	slow irregular	good crying		
Muscle tone	flaccid	any body movement	active motion		
Reflex Irritability	no response	grimace	cry		
Color	blue pale	body pink extremities blue	completely pink		
			Total		

II. Interpretation and Importance of the Apgar Scoring Technique

1. Observations are made and recorded at one and five minutes after delivery. The values given are then added up. 7-10 idicates a vigorous infant; 4-6 a depressed infant; and 0-3 a markedly depressed infant.
2. For greatest validity observations should be made and recorded by specially trained and impartial observers. This may include the delivering doctor.
3. Even though a low apgar score (A.S.) can reflect an underlying pathologic condition or may reflect a recent traumatic event, the A.S. has only *prognostic* and *not* true diagnostic importance for the newborn. Therefore infants with low A.S. (less than 6) need careful observation and frequently, continuing specialized medical management.
4. The smaller the infant and the lower the A.S., the higher the overall mortality.
5. The value of the low 1 minute A.S. is in identification of the newborn in need of immediate attention and in indicating a rough assessment of the acid-base status of the infant.

6. The value of the low 5 minute A.S. is in identification of the newborn at highest mortality risk or at greatest risk of later neurologic morbidity. This is especially true of small infants.
7. Mortality in infants with low A.S. is greatest in the first 2 days of life. Death can occur at any time during the neonatal period.
8. Where potential problems are anticipated before delivering, consultation and possible transfer of the undelivered mother to a delivering facility that also includes a center for special care of the infant (such as an NICU) should be considered.

Prepared for the Committee on Maternal and Perinatal Health, Michigan State Medical Society by Paul M. Zavell, MD of Harper Woods.

MATERNAL HEALTH DESK REFERENCE CARD NO. 21

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society)

IMPORTANT SIGNS AND SYMPTOMS OF THE NEWBORN

(Also see Card #20 *"IMPORTANT NEWBORN SIGNS AND SYMPTOMS IN THE DELIVERY ROOM")*

This card (Card #21) is not meant to be complete. It is to be used in conjunction with The Apgar Technique of Scoring: (See card #20). Interpretation can be difficult and consultation may be indicated. Knowledge of family medical history, as well as full details of the pregnancy, including labor and delivery, is very important.

NEWBORN ASSESSMENT OF GESTATIONAL AGE
(Modified after Dubowitz, et al)

AGE	Breast Tissue and Areola	Skin	Ear	Male Genitalia	Female Genitalia
28 wks	Nipple barely visible. No palpable breast tissue.	Thin, translucent, edema. Lanugo hair over face & body	Pinna Soft Stays folded.	+/-testes in inguinal canal. +/-rugae on anterior surface of scrotum.	Prominent clitoris & labia minora. Early rudiments of labia majora.
32 wks	Raised nipple and areola.	Smooth, thicker. No edema. No. Lanugo on face.	Cartilage scant. Returns slowly from folding	Testes palpable in inguinal canal. Few rugae on anterior surface of scrotum.	Prominent clitoris. Labia majora small & widely separated.
36 wks	1-2 mm breast	Pink. Few vessels. Marbeling effect.	Thin cartilage. Springs back from folding.	Testes in upper scrotum. Rugae extend to lateral surface of scrotum.	Labia majora larger. Nearly cover labia minora & clitoris.
40 wks	6-10 mm breast	Keratiginous. Some desquamation.	Pinna firm with thick cartilage. Difficult to fold.	Testes in lower scrotum. Pendulous scrotum with rugae on posterior surface.	Labia minora & clitoris covered. Rugae may be present on labia majora.

SIZE		
SIGN OR SYMPTOM	**Possible Reasons (s)**	**Major Infant Difficulties**
1. LARGE INFANT* (Large for gestational age — usually 4000 gm)	1. Undetected maternal diabetes	Hypoglycemia, convulsions, CNS injury
	2. Hydrops	Anemia, Heart failure
	3. Beckwith Syndrome	Hypoglycemia
2. SMALL INFANT* (Small for gestational age — usually 2500 gm) *According to the University of Colorado Classification chart using birth weight and gestational age by Lubchenco	1. "Premature" (appropriate for gastational age)	Respiratory Distress Syndrome (RDS), CNS injury, Hypoglycemia
	2a. Malnutrition or "wasted baby"	Respiratory problems, mental deficiency, Hypoglycemia, Polycythemia
	2b. Rubella	Stigmata of Rubella (see)
	2c. Chromosomal Abnormalities (small for gestational age)	Multiple

SKIN		
SIGN OR SYMPTOM	**Possible Reason(s)**	**Major Infant Difficulties**
1. WHITE OR GRAY (pale)	1. Fetal hemorrhage (to maternal, into major organ, blood incompatibility, intrauterine infection)	RDS, Heart Failure, Sepsis
	2. Respiratory	Early RDS, Mild atelectasis
	3. Chilled Infant	RDS
2 RED (Plethora)	1. Maternal to fetal transfusion	RDS, Heart Failure
	2. Placental transfusion	Hyperbilirubinemia
	3. Hyperviscosity Syndrome (Idiopathic polycythemia)	RDS, Heart Failure, CNS Problems
3. SPOTTED RED (Multiple hemangiomata)	1. Not Known (Hereditary?)	Hemorrhage, secondary infection, respiratory or GI problem
	2. Sterge Weber Syndrome	Not Immediate
4a. PINPOINT RED (generalized)	1. Maternal drugs (thiazides)	
	2. Maternal ITP, LE	
	3. Cytomegalic Disease	Possible hemorrhage
	4. Idiopathic	
	5. Maternal Syphillis	Congenital Lues
	6. Bacterial Infection	Sepsis
	7. Protozoan Infection (Taxoplasmosis)	Mental Retardation
4b. PINPOINT RED (Face and neck petechial)	1. Face presentation	CNS or Cord Injury
	2. Cord around neck	Uncommon
5. BLUE (Cyanosis)	1. Congenital Heart Disease	Heart Failure, Respiratory Difficulties
	2. CNS Injury	Respiratory Difficulties, Convulsions
	3. Abnormal Respiratory Tract	RDS, Pneumonia
	4. Drugs to Mother	CNS Depression, anoxic injury
6. BROWN-GREEN (Meconium Stained)	Multiple Intrauterine Crisis	Sepsis, Blood incompatibility, CNS Injury, Aspiration and Respiratory difficulties
7. YELLOW-GREEN (Jaundice)	Hydrops	Blood Incompatibility problem
8. PATCHY-BLUE (Blueberry Muffin) ***	Rubella	Stigmata includes microcephaly cardiac defects, deafness, jaundice, plus hepatitis
9. PEELING ***	Post Term (Intrauterine Infection)	Jaundice, Sepsis
10. "BLISTERS" ***	1. Pyoderma	Sepsis, jaundice
	2. Herpes Simplex	CNS Injury, chorioretinitis
	3. Chicken Pox (Rare)	Cicatricial scarring, Hypoplastic Extremity
***isolation may be in order	4. Milia Crystallina	NONE

HEAD, FACE AND NECK		
SIGN OR SYMPTOM	**Possible Reason(s)**	**Major Infant Difficulties**
1a. SIZE (Large — 37 cm. circum.)	1. Hydrocephaly	Mental Retardation
	2. Hereditary	NONE
1b. SIZE (Small — 33 cm. circum.)	Microcephalia	Mental Retardation
2. UNUSUAL SHAPE	1. Anencephalic	Death
	2. Scalp Hemangioma	Hemorrhage
	3. Scalp Tumor	Encephalocele
	4. Cephalohematoma	Hyperbilirubienmia and anemia
	5. Subdural Hematoma	Brain Damage, convulsions
3. UNUSUAL FACIAL APPEARANCE	1. Mongolism and Chromosomal abnormalities	Multiple system problems
	2. Fetal Alcohol Syndrome	Small, retarded infant
4. UNUSUAL EARS	Chromosomal abnormality	GU Problems, Mental Retardation
5. RECEDING CHIN	Pierre Robin Syndrome	Respiratory and/or Feeding
6. LARGE TONGUE	1. Beckwith Syndrome	Hypoglycemia
	2. Mongolism	Congenital heart, Intestinal obstruction
	3. Cretinism	Mental Retardation
7. MOUTH BREATHER	1. Choanal Atresia	Respiratory
	2. Mucous obstruction	
8. NASAL FLARING	1. Aspiration	Pneumonia
	2. Hyaline Membrane Disease	
9a. NECK MASS (Midline)	Goiter	Thyroid Difficulties
9b. NECK MASS (Lateral)	1. Cystic Hygroma	Respiratory Difficulties
	2. Branchial Cleft Cyst	
BODY		
SIGN OR SYMPTOM	**Possible Reason(s)**	**Major Infant Difficulties**
1. ARCHING TRUNK	CNS Bleeding or Injury	RDS, Cyanosis
2. RIB RETRACTIONS	1. Atelectasis 2. Aspiration 3. Pneumonia 4. RDS	Respiratory Tract Problem
3. ABDOMEN	1. GI Obstruction (Meconuim Illeous)	Vomiting
a. DISTENTION	2. Tumor (Hydronephrosis)	GU Problem
	3. Ascites	Liver Problem, Heart Failure
b. Scaphoid	Diaphragmatic Hernia	Respiratory Problem, Death
4. UMBILICAL CORD		
a. Two Vessels	Possible Congenital Abnormalities	Possible GU Problem
b. Meconuim Stained	1. Intrauterine Fetal Distress	Variable
	2. Isoimmunization	Jaundice, anemia
c. Large	1. Omphalocele	Infection
	2. Cretinism	(See under LARGE TONGUE)
	3. Mongolism	(See under LARGE TONGUE)
5. IMPERFORATE ANUS	Congenital anomaly	GI Obstruction

GENITALIA		
SIGN OR SYMPTOM	**Possible Reason(s)**	**Major Infant Difficulties**
1. AMBIGUOUS OR GROSSLY ABNORMAL	1. Endocrine Problem	Sex Determination
	2. Adrenogenital Syndrome with or without salt losing	GU-GI Problem Vomiting, Dehydration
2. SCROTAL SWELLING	1. Hernia	Strangulation of Intestine
	2. Torsion of Testicle	Loss of Testicle
	3. Hydrocele	Associated Hernia (?)
EXTREMITIES		
SIGN OR SYMPTOM	**Possible Reason(s)**	**Major Infant Difficulties**
1. FAILURE TO MOVE: a. Arm	1. Erbs Palsy	Neurologic and/or orthopedic
	2. Fracture, esp. clavicle or humerus	Diaphragmatic Paralysis
b. Hand	Klumpke Palsy (Breech Delivery?)	Brachial Paralysis Diaphragmatic Paralysis
2. WEBBED FINGERS	Syndactylism (Congenital Anomaly)	Variable
3. EXTRA FINGERS OR TOES	Polydactylism (Hereditary)	Usually None
MISCELLANEOUS		
SIGN OR SYMPTOM	**Possible Reason(s)**	**Major Infant Difficulties**
1. GRUNTING	Variable Respiratory Problems	RDS
2. PAINFUL CRY	Fracture, such as Clavicle, Humerus, Tumor, etc. Intracranial Hemorrhage	Variable

Prepared for the Committee on Maternal and Perinatal Health, Michigan State Medical Society by Paul M. Zavell, MD of Harper Woods.

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

category 1 programs

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

DATE: 10/26, 11/23, 12/28, Psychiatry: Special Case Seminar
LOCATION: Sinai Hospital of Detroit — West Conference Room
SPONSOR: Sinai Hospital
FOR: Psychiatrists
COST: None
CONTACT: Office of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit, 48235, (313) 272-6000
APPROVED FOR: 2 hours of Category I Credit per session

* * *

DATE: 10/12, 11/9, 12/14, Special Problems Seminar — Psychiatry
LOCATION: Sinai Hospital
SPONSOR: Sinai Hospital
FOR: Psychiatrists
COST: None
CONTACT: Office of CME, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit, 48235 (313) 272-6000
APPROVED FOR: 2 Hours of Category I Credit per session

* * *

DATE: Oct. 14-15, Psychosexual Counseling
LOCATION: Ramada Inn, Saginaw
SPONSOR: Saginaw Cooperative Hospitals, Inc.
FOR: Obstetricians-gynecologists, psychiatrists, general practitioners
COST: $100
CONTACT: Robert K. Barton, MD, (517) 753-2427, Saginaw
APPROVED FOR: 12 hours of Category I Credit

* * *

DATE: October 14-16, Family Practice Review
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: Michigan Academy of Family Physicians
COST: $170
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 23½ hours of Category I credit

* * *

DATE: October 19-21, Cardiology for Internists
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $170
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 22½ hours of Category I credit

* * *

DATE: October 22-23, Psychiatry Conference, "Common Problems in Child and Adolescent Psychiatry"
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: $80
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 11¼ hours of Category I credit

* * *

DATE: Oct. 28-30, The Human Vagina: Biological and Clinical Aspects
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit, 48201
SPONSOR: WSU Department of Obstetrics/Gynecology
FOR: Obstetricians/Gynecologists
COST: $100
CONTACT: WSU Division of CME**
APPROVED FOR: 20 hours of Category I Credit

* * *

DATE: Nov. 3, New Concepts in Neurologic Treatment and Diagnosis
LOCATION: Hospitality Motor Inn, Grand Rapids
SPONSOR: Divisions of Neurology and Neurosurgery, Blodgett Memorial Medical Center
FOR: Primary physicians
COST: $30
CONTACT: Oliver D. Grin, Jr., MD or John F. Butzer, MD, Blodgett Memorial Medical Center, 1840 Wealthy St., SE, Grand Rapids
APPROVED FOR: 7 hours of Category I Credit

* * *

DATE: Nov. 3, Sleep Disorders
LOCATION: Towsley Center, University of Michigan Medical Center
SPONSOR: U of M Medical School Departments of PGM & HPE
CO-SPONSOR: Sleep Disorders Clinic, Stanford University School of Medicine
FOR: Psychiatrists, neurologists, family physicians
COST: $25
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 8 hours of Category I Credit

* * *

DATE: Nov. 6, Ophthalmology for the Primary Care Physician
LOCATION: Detroit Institute of Ophthalmology, 15401 East Jefferson, Grosse Pointe Park
SPONSOR: The Detroit Institute of Ophthalmology
CO-SPONSOR: Bon Secours Hospital
FOR: Family physicians
COST: $50
CONTACT: Detroit Inst of Ophthalmology, (313) 824-4710
APPROVED FOR: 5 hours of Category I Credit

(Continued on page 585)

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Please print and return to:

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535 North Dearborn Street
Chicago, Illinois 60610

General Registration

______ AMA members and their guests: no fee
______ Non-member physicians: $35
______ Guests of non-members: $10 per person
______ Medical students, interns, residents, Canadian, and foreign physicians: no fee

Does not include CME Course, Sessions, or Luncheons Fees.

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______________________________________.

If not, I have added $35 non-member fee to my course registration remittance of $__________, which is enclosed in the form of a check or money order payable to the American Medical Association. I understand payment must accompany my choice of course(s) on this registration coupon.

Confirmation of my selection(s) will be mailed to me according to the deadlines itemized. Please send AMA's Philadelphia Clinical Convention Brochure ☐.

Name ______________________________

Office Address ______________________________

City/State/Zip ______________________________

Office Phone No. ______________________________

Course Code	Credit Hours	Fees	Number of Preferences			
			Sat.	Sun.	Mon.	Tue.
S-1	5	$ 50	____			
S-2.	6	60	____			
S-3.	6	60	____			
S-4.	6	60	____			
S-5.	3	30	____			
S-6.	3	30	____			
S-7.	5	50	____			
S-8.	3	30	____			
S-9.	3	30	____			
S-10	3	30	____			
S-11.	11	130	____	____		
S-12.	6	60	____	____		
S-13.	6	60	____	____		
S-14.	6	60	____	____		
S-15.	6	60	____	____		
S-16.	6	60	____	____		
S-17.	3	30		____		
S-18.	3	30		____		
S-19.	3	30		____		
S-20.	3	30		____		
S-21.	3	30		____		
S-22.	3	30		____		
S-23.	12	120		____	____	
S-24.	6	60		____	____	
S-25.	6	60		____	____	
S-26.	3	30			____	
S-27.	3	30			____	
S-28.	3	30			____	
S-29.	3	30			____	
S-30.	3	30			____	
S-31	3	30			____	
S-32	6	60			____	____
S-33.	6	60			____	____
S-34.	6	60			____	____
S-35.	6	60			____	____
S-36	6	60			____	____
S-37.	5	50				____
S-38.	3	30				____
~~S-39.~~	~~3~~	~~30~~				____
S-40	3	30				____
S-41.	3	30				____
S-42.	3	30				____
S-43.	5	50				____
S-44.	3	30				____
~~S-45.~~	~~3~~	~~30~~				____
S-46	3	30				____

Add $35 if Non-AMA Member ....____________

TOTAL ....____________

Special Note • In addition to the postgraduate courses outlined here, the Oct. 11, 1976, **JAMA** Convention Issue contains 9 general sessions, 16 luncheon sessions, and 32 "Meet the Professor" meetings available to you. The AMA's Philadelphia Clin cal Convention Brochure also contains this information. All inquiries should be directed to the **AMA Department of Meetin Services, 535 N. Dearborn St., Chicago, IL 60610** and or direct phone inquiries to: **AMA Department of Meeting Services a (312) 751-6187.**

CME program tailored to your needs • The primary purse of the AMA Clinical program is to provide you with a oad-based, multidisciplinary learning experience which is ually not available in specialty society continuing medical ucation (CME) programs. For this purpose, the scientific ogram features an exceptionally large and broad selection Category 1 postgraduate courses which provide credits ward the AMA Physician's Recognition Award. In fact, the ientific program is the largest ever offered at an AMA inical Convention.

In Category 1, you can choose from 46 postgraduate urses, 9 general sessions, telecourses, living teaching monstrations, and conducted exhibit rounds. In addition, ategory 2 credits can be obtained by paid attendance at 16 ncheon and 32 "Meet the Professor" sessions.

The Bicentennial City • It is particularly appropriate in this Bicentennial Year that Philadelphia be the site of AMA's 30th Clinical Convention. Because Philadelphia is not only the birthplace of our Nation, but it can also lay legitimate claim to being the cradle of American medicine. It is the site of the first hospital, the first medical school, and the home of many famous American Colonial physicians, such as Benjamin Rush, John Shippen, and John Morgan.

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Plan Now for Your CME in Philadelphia • Use the coupon register now for the postgraduate courses of your oice. The complete selection and full descriptions of the er 103 CME events will be available in the October 11, 76, Clinical Convention Issue of the **Journal of the Ameri-n Medical Association (JAMA).** You may also check the upon box to receive the AMA's Philadelphia Clinical onvention Brochure which has material similar to the MA Convention Issue. After filling in information, send is coupon to the AMA with your accompanying check or oney order. Advance registration requests must be reived by October 29, 1976. Course tickets and registration materials will be sent to you on November 12, 1976. All tickets requested after that deadline date will be held for pickup at the Postgraduate Registration Desk in the Philadelphia Civic Center.

If the minimum course registration is not attained for your first choice, or if the course is full, one of your alternate choices will be substituted. It is best to register early because the class sizes are limited. All medical students, interns, and residents are entitled to a 50% discount on postgraduate course fees ($10 per Category 1 credit hour is standard rate).

ostgraduate Courses

turday, Dec. 4, 1976

0 AM-Noon (5 hours: $50)

*S-1. Basic Life Support (Cardiopulmonary Resuscitation—CPR)

0 AM-5:30 PM (6 hours: $60)

S-2. Practice Management Seminar
S-3. Writing for Scientific Journals
*S-4. Nutrition: Parenteral & Alimentary

0 AM-Noon (3 hours: $30 each)

*S-5. Basic Electrocardiography
S-6. Evaluation of the Dizzy Patient

00-5:30 PM (5 hours: $50)

S-7. Basic Life Support (CPR)

30-5:30 PM (3 hours: $30 each)

S-8. Hematologic Disorders in Children
S-9. The Eye & Office Practice
S-10. Coronary Artery Disease: Medical vs Surgical Therapy

at., Dec. 4 & Sun., Dec. 5

00 AM-5:30 PM & 9:00 AM-Noon (11 hours: $110, plus 0 lab fee = $130)

S-11. Public Speaking Seminar

00 AM-Noon & 9:00 AM-Noon (6 hours: $60 each)

*S-12. Fluid & Electrolyte Therapy
S-13. Diseases of the Bowel
S-14. Arthritis Update: Medical & Surgical Management

:30-5:30 PM & 2:30-5:30 PM (6 hours: $60 each)

*S-15. Management of Diabetes Mellitus
S-16. Hypertension

unday, Dec. 5, 1976

:00 AM-Noon (3 hours: $30 each)

S-17. Diagnosis & Treatment of Fractures of the Upper Extremities
*S-18. Advanced Electrocardiography
S-19. Emergency Medicine

:30-5:30 PM (3 hours: $30 each)

*S-20. Pulmonary Function & Blood Gases
S-21. Behavioral Problems Involving Children & Adolescents
S-22. Recent Advances in Cancer Surgery

Sun., Dec. 5 & Mon., Dec. 6

:30 AM-5:30 PM & 7:30 AM-Noon (12 hours: $120)

S-23. Advanced Life Support (CPR)

9:00 AM-Noon & 9:00 AM-Noon (6 hours: $60)

S-24. Jaundice: Diagnosis, Treatment & Management

2:30-5:30 PM & 9:00 AM-Noon (6 hours: $60)

S-25. Everything You Want to Know About New Diagnostic Techniques: Scoping, Scanning, & Angiography

Monday, Dec. 6, 1976

9:00 AM-Noon (3 hours: $30 each)

S-26. Diagnosis & Treatment of Fractures of the Lower Extremities
S-27. Neonatology
S-28. Current Controversies in Gynecology

2:30-5:30 PM (3 hours: $30 each)

S-29. Basic Electrocardiography
S-30. Pulmonary Function & Blood Gases
*S-31. Complications of Psychotropic Drugs

Mon., Dec. 6 & Tues., Dec. 7

9:00 AM-Noon & 9:00 AM-Noon (6 hours: $60 each)

S-32. Immunology 1976
S-33. Thromboembolism: Prevention, Diagnosis, & Treatment

2:30-5:30 PM & 2:30-5:30 PM (6 hours: $60 each)

S-34. Fluid & Electrolyte Therapy
S-35. Nutrition: Parenteral & Alimentary
S-36. Management of Diabetes Mellitus

Tuesday, Dec. 7, 1976

7:30 AM-Noon (5 hours: $50)

S-37. Basic Life Support (CPR)

9:00 AM-Noon (3 hours: $30 each)

S-38. Diagnosis & Treatment of Fractures in Children
~~*S-39. Dermatology for the Nondermatologist~~
S-40. Allergic Emergencies
S-41. Medical Problems in Long-Term Care
S-42. Acute Hand Problems

1:00-5:30 PM (5 hours: $50)

S-43. Basic Life Support (CPR)

2:30-5:30 PM (3 hours: $30 each)

S-44. Advanced Electrocardiography
~~S-45. Dermatology for the Nondermatologist~~
S-46. Complications of Psychotropic Drugs

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*Course repeated. See course list for dates & times.

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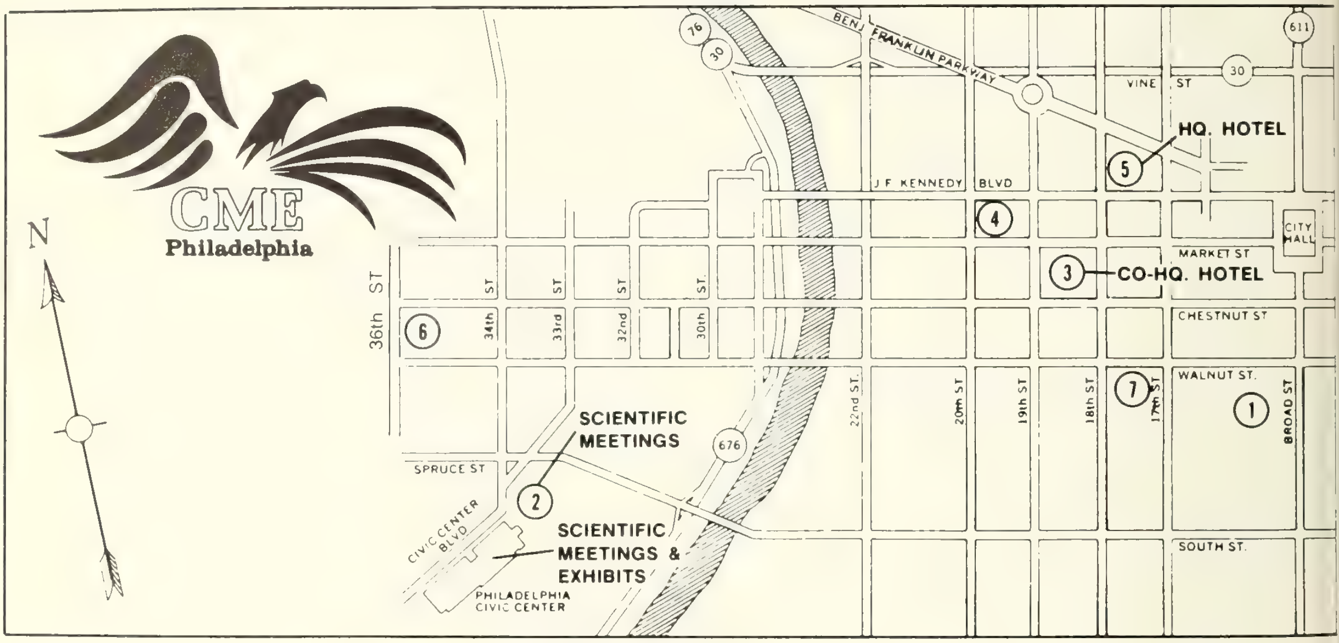
Housing Form

Key #	Hotel/Motel	Single	Double	Twin	Suite
1	Bellevue Stratford	$27.00-40.00	$34.00-47.00	$34.00-47.00	$ 60.00-105.00 (1 Bedroom) 107.00-152.00 (2 Bedrooms
2	Hilton of Philadelphia	30.00-40.00	40.00-50.00	40.00-50.00	110.00-190.00 (1 Bedroom) 160.00-250.00 (2 Bedrooms
3.	**Holiday Inn — Center City**	**CO-HEADQUARTERS HOTEL**		**NO ROOMS AVAILABLE**	
4.	Penn Center Inn	25.00-27.00	30.00-32.00	30.00-32.00	60.00 (1 Bedroom) 90.00 (2 Bedrooms)
5	**Philadelphia Sheraton**	**HEADQUARTERS HOTEL**		**NO ROOMS AVAILABLE**	
6.	University City-Holiday Inn	29.00	36.00	36.00	95.00-105.00 (1 Bedroom)
7.	Warwick Hotel	32.00-38.00	38.00-44.00	38.00-44.00	75.00-100.00 (1 Bedroom) 100.00-150.00 (2 Bedrooms

THE ABOVE RATES ARE SUBJECT TO A 6% HOUSE OCCUPANCY TAX.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Please print or type four choices

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Please enter my reservation at the above hotel/motel for

Single(s) __ at $ __________ **Double(s)** __ at $ __________

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Please add 6% for the House Occupancy Tax; if your rate requested is not available, the next highest rate will be assigned. **DO NOT** send your request directly to the hotel; it will only delay your confirmation. Kindly make all necessary changes and cancellations directly with the Housing Bureau in Philadelphia, and be sure and specify your time of arrival, as well as the date. If you are an Industrial Exhibitor, please specify your firm's name and the list of all the occupants for all the rooms that you are reserving.

CONFIRMATIONS WILL BE MAILED UP TO NOVEMBER 12, 1976.

Room will be occupied by

Name ______________________________
(Please print or type.)

Firm ______________________________

Address ______________________________

City/State/Zip Code ______________________________

Office Phone Number (   ) _____ - __________

Additional Occupants (List ages of children, if any)

____

Arrival Date __________ at _____ AM, PM; Departure Date __________

DATE: November 8-9, Abnormal Hemoglobin and Thalassemia
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
CO-SPONSOR: American Society of Medical Technologists
COST: $70
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: 14½ hours of Category I credit

* * *

DATE: November 9-10-11, Michigan State Medical Society Annual Scientific Meeting
LOCATION: Hyatt Regency Hotel, Dearborn
SPONSOR: MSMS Committee for CME Programming
FEATURING: 49 Category I Courses, sponsored by statewide medical specialty societies and the MSMS Committee; taught by outstanding Michigan medical educators and practitioners and out-of-state authorities.
COST: $5 per credit hour for MSMS members; $10 per credit hour for non-members; no charge for residents and interns.
CONTACT: Herbert A. Auer, MSMS
APPROVED FOR: Category I credit; maximum during three days would be 25.
REGISTRATION: Registration forms, etc., will appear in early September MSMS Medigram.

DATE: Nov. 11-12, Gynecology/Obstetrics Update and George Kamperman Memorial Lecture
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit, 48201
SPONSOR: Wayne State University, Department of Gynecology and Obstetrics
FOR: Gynecologists/Obstetricians
COST: $75
CONTACT: WSU-Division of CME**
APPROVED FOR: 12 hours of Category I Credit

* * *

DATE: Nov. 16, Management of Advanced Cancer of the Breast
LOCATION: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207
SPONSOR: WSU Department of Oncology
FOR: Oncologists
COST: $20
CONTACT: WSU-Division of CME**
APPROVED FOR: 2½ hours of Category I Credit

* * *

DATE: Nov. 17, Annual Thyroid Workshop
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit, 48207
SPONSOR: WSU Department of Internal Medicine
FOR: All interested physicians
COST: $20
CONTACT: WSU Division of CME**
APPROVED FOR: 6 hours of Category I Credit

* * *

DATE: November 17-18, Second Annual Pulmonary Seminar for Family Physicians
LOCATION: Harper/Webber Auditorium, Detroit Medical Center
SPONSOR: WSU School of Medicine, Departments of Family Medicine, Internal Medicine-Pulmonary Division, Pediatrics, and Div. of Postgraduate and CME; Michigan

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The following have been accredited by MSMS Commission on Continuing Medical Education as of Sept. 1, 1976.

Organizations:

Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
University of Michigan
  School of Public Health, Ann Arbor

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Detroit-Macomb Hospital Association
Grace Hospital, Detroit
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Southfield
Saginaw Cooperative Hospitals Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V.A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
Ypsilanti State Hospital, Ypsilanti

welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Martin F. Abbert, MD
2611 Morton Ave.
St. Joseph 49085

David P. Bottomy, MD
450 Long Rapids Rd.
Alpena 49707

Louis L. Constan, MD
3304 Davenport
Saginaw 48603

Walter S. Cukrowski, MD
4200 N. Woodward Ave.
Royal Oak 48072

Myron M. Faber, MD
Dept. of Human Dev. — MSU
East Lansing 48824

Neil E. Grossnickle, MD
Sand Point Rd.
Munising 49862

Saib Isterabadi, MD
3178 Rogers St.
Marlette 48453

Don E. Keener, MD
Mill Rd.
Adrian 49221

Henry Ottens, MD
1420 Wisconsin
Grand Haven 49417

Shirley J. Robertson, MD
503 Division
East Lansing 48823

Duen-Shung Shih, MD
St. Joseph Mercy Hosp. — Anesth.
Pontiac 48053

Ronald S. Taylor, MD
3535 W. 13 Mile Rd. #302
Royal Oak 48072

Humphrey Uddoh, MD
1217 S. 11th St.
Niles 49120

CME COURSES/*Continued*

Academy of Family Physicians; American Lung Association of SE Michigan
FOR: All interested physicians
COST: $60.00
CONTACT: Miss Gibson or Mrs. Murray, American Lung Association of SE Michigan (313) 961-1697
APPROVED FOR: 16 Hours of Category I Credit

* * *

DATE: November 23, Continuing Pathology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education
COST: Undetermined
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Undetermined hours of Category I credit

DATE: Nov. 26-29, Ophthalmology: Basic and Clinical Review
LOCATION: Dearborn Inn
SPONSOR: Kresge Eye Institute, WSU School of Medicine
FOR: Ophthalmologists
COST: $400
CONTACT: Arthur Sapere, Program Registrant, McGregor Memorial Conference Center, Wayne State University, Detroit, 48202
APPROVED FOR: 40 hours of Category I credit

* * *

DATE: Dec. 1, Cardiology for Family Physicians
LOCATION: Towsley Center for Continuing Medical Education, University of Michigan
SPONSOR: U-M Office of Intramural Education, Dept. of Postgraduate Medicine & Health Professions Education
CO-SPONSOR: Michigan Academy of Family Practice
FOR: All interested physicians
COST: $60
CONTACT: Office of Intramural Education, Dept. of PGM/HPE, Univ. of Michigan
APPROVED FOR: 8 hours of Category I credit

* * *

DATE: Dec. 1-3, Introduction to Data Retrieval and Display
LOCATION: Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, 48105
SPONSOR: Commission on Professional and Hospital Activities
FOR: PAS member hospital teams
COST: $180
CONTACT: CPHA, 1968 Green Road, Ann Arbor 48105

APPROVED FOR: 9 hours of Category I Credit

* * *

DATE: Dec. 5-6, Symposium on Trauma
LOCATION: Harper Hospital, Detroit
SPONSOR: Wayne State University Department of Surgery
FOR: All interested physicians
COST: $100
CONTACT: WSU Division of CME**
APPROVED FOR: 10 hours of Category I Credit

* * *

DATE: Jan. 4-Mar. 22, Radiologic Physics II
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
SPONSOR: WSU Department of Radiology
FOR: All interested physicians
COST: $66
CONTACT: WSU Division of CME**
APPROVED FOR: 2 hours per session, 20 course hours of Category I Credit

* * *

DATE: Jan. 5-March 23, Clinical Nuclear Medicine I
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit, 48201
SPONSOR: WSU Department of Radiology
FOR: All interested physicians
COST: $66
CONTACT: WSU Division of CME**
APPROVED FOR: 2 hours per session, 20 course hours of Category I Credit

* * *

DATE: Jan. 10-Mar. 26, Pathophysiology of Hemostasis
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit, 48201
SPONSOR: WSU-Department of Pathology
FOR: All interested physicians
COST: $100
CONTACT: WSU Division of CME**
APPROVED FOR: 2 hours per session, 20 course hours of Category I Credit

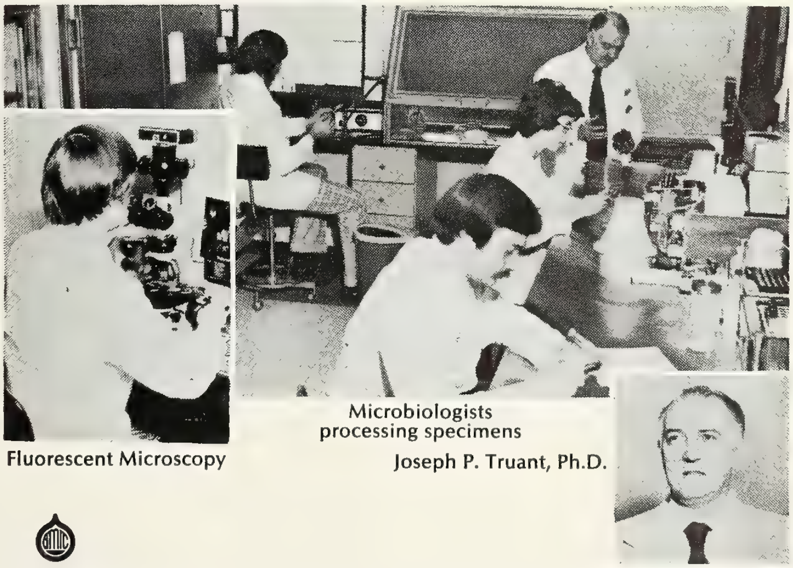
* * *

DATE: Jan. 17-21, Topics in Emergency Medicine
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
SPONSOR: WSU Department of Surgery
FOR: All interested physicians
COST: $150
CONTACT: WSU Division of CME**
APPROVED FOR: 30 hours of Category I Credit

* * *

DATE: Jan. 18, Detroit Cancer Club Seminar, Carcinoma of the Lung
LOCATION: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207
SPONSOR: WSU School of Medicine, Department of Oncology

AMRC Microbiology Department



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COST: $20
CONTACT: WSU Division of CME** or Melvin L. Reed, MD, 4160 John R., Detroit, 48201
APPROVED FOR: 2½ hours of Category I Credit

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

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FIAC

DATE: March 15, Cancer of the Colon and Rectum
LOCATION: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207
SPONSOR: WSU Department of Oncology
FOR: All interested physicians
COST: $20
CONTACT: WSU Division of CME**
APPROVED FOR: 2½ hours of Category I Credit

Continuing Courses

DATE: Every Friday, through June, 1977, Neurology Conference
LOCATION: 4 Morse Auditorium, Harper Hospital
SPONSOR: Wayne State University Department of Neurology
FOR: Internists, neurologists, neurosurgeons, pediatricians, family doctors
COST: None
CONTACT: Beverly Wolf, Department of Neurology, 3990 John R, Detroit, 48201
APPROVED FOR: 2 Category I hours

* * *

DATE: Every Saturday, Weekly Conference
LOCATION: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey
SPONSOR: Burns Clinic/Little Traverse Hospital
FOR: All interested physicians
COST: None
CONTACT: Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770
APPROVED FOR: Hour-for-hour Category I Credit

* * *

DATE: Begins September, 1976, Continuing Training in Family Therapy
LOCATION: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield
SPONSOR: Family Institute of Southeastern Michigan
CO-SPONSOR: Ackerman Institute
FOR: Psychotherapists
COST: Varies according to time put in
CONTACT: Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan
APPROVED FOR: Hours vary with time spent

* * *

DATE: Saturdays, Morbidity and Mortality Conference
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital Department of Surgery
FOR: Surgeons
COST: None
CONTACT: Office of CME, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit, 48235 (313) 272-6000
APPROVED FOR: 2 hours of Category I Credit per session

* * *

DATE: Monthly, Cleft Palate Clinic
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Oral Surgeons, plastic surgeons, pediatricians
COST: None
CONTACT: Office of CME, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit, 48235, (313) 272-6000
APPROVED FOR: 3 hours of Category I Credit

* * *

Michigan Psychiatric Society offers guidelines for sex therapists

The Michigan Psychiatric Society has formulated guidelines for qualifications of therapists in the treatment of sexual dysfunction. The guidelines, in the form of a position statement, are printed here.

1. The therapist should possess knowledge of and experience in the application of basic psychotherapy treatment programs and principles of human learning. This knowledge should be manifested through the possession of a degree in a health care field. This would include the degrees of MD, DO, PhD, MSW, RN, and other such degrees.

2. The therapist should be certified and licensed by the state to work in some area of the health care field, and should be able to take a complete medical and psychiatric history.

3. The therapist should be personally secure and confident of his/her knowledge of sexual physiology and aware of current research findings in this field.

4. The therapist should be capable of assuming an authoritative role in counseling with patients.

5. The therapist should have a knowledge of emotional disorders and appropriate treatment and/or referral for such disorders combined with the ability to determine appropriate referral and to recognize the limits of his/her own range of interventive competence.

6. The therapist should be as cognizant or understanding of his/her own sexual responsiveness and be able to place that responsiveness in perspective.

7. The therapist should conduct or require physical examination of patients to be treated for sexual distress and have the ability to interpret the results of such examination to the patient.

8. The therapist should have sufficient knowledge and ability to work with various aspects of sexual distress including communicational difficulties, metabolic limitations, neurological, gynecological, urological, and other physically based incapacities and the consequences of the aging process.

9. Physical sexual intimacy should be limited to the interaction between the patient and his or her partner of choice in private.

10. The therapist should not engage in intimate physical interaction with his or her clients at any time during the treatment program or follow-up period.

11. The therapist should be available to patients for follow-up following the intensive phase of treatment. This might follow a one-month, three-month, one-year sequence.

12. The therapist should present evidence of continuing education in the field of psychotherapy and human sexual functioning.

13. The therapist should, at all times, protect the privacy and confidentiality of his or her clients. All sexual intimacy engaged in by the client(s) should be done in the privacy of their own home and *not* under the direct supervision or observation of the therapist.

14. In addition to the above qualifications, the therapist should show evidence of, express interest in, and demonstrate ability to, teach in the field of human sexuality.

MSMS task force surveys teaching of family planning

A better understanding of the information Michigan doctors need to assist their patients with sexual problems and family planning is now held by an MSMS task force.

The subcommittee of the MSMS Maternal and Perinatal Health Committee, led by Gerald B. Holzman, MD, East Lansing, was given the assignment of developing a family planning training program for physicians in rural areas after a $5,000 grant for the purpose was made to MSMS by the Michigan Department of Public Health.

The subcommittee's first step was to survey rural family physicians, obstetricians, gynecologists, pediatricians and general surgeons to determine what family planning information they need and want.

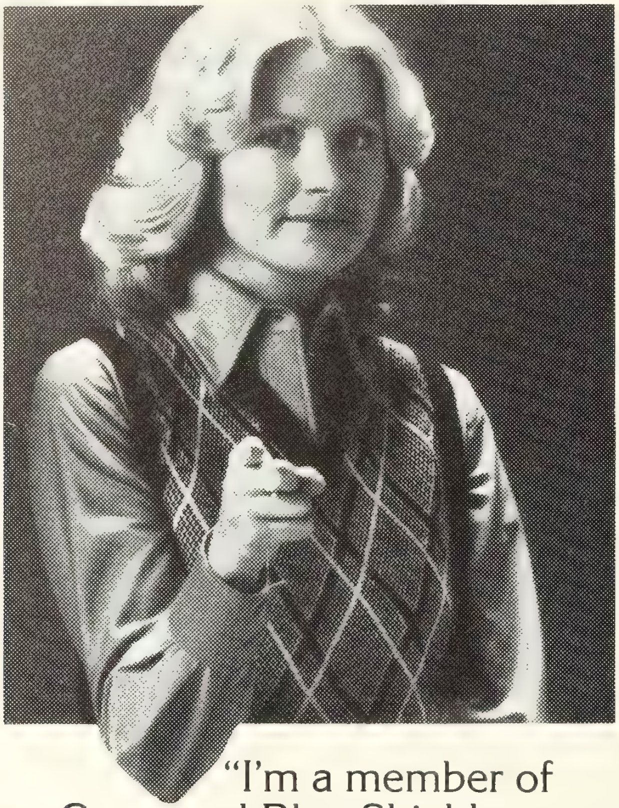
The result was three day-long symposiums on human sexuality problems, combining lectures and physician interviews of patients with problems. The conferences were held in Lansing, Petoskey and Marquette earlier this year.

The physicians who attended learned more about recognizing patients' behavioral cues to underlying sexual problems, dealing with the embarrassment of discussing patients' sexual problems in the office and the differentiation between sexual problems which can be treated in the office and those which should be referred to other professionals.

Doctor Holzman and his committee now are analyzing the evaluations of participating physicians. They don't expect the committee to continue such programs unless the public health department should grant more funds to MSMS to do so.

Their observations will be reported further to MSMS members. In addition, the committee plans to contact physicians who attended the seminars to determine whether they are treating more problems of sexual dysfunction since their symposium experience.

I want you.



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In Memoriam

Donald Boersma, MD
Grand Rapids

Grand Rapids dermatologist Donald Boersma, MD, died Sept. 4 at the age of 65. Doctor Boersma was a diplomate of the American Board of Dermatology and was graduated from the University of Chicago Medical School. He was affiliated with Blodgett and Butterworth hospitals in Grand Rapids.

John C. Dodds, MD
Detroit

Long-time Detroit urologist John C. Dodds, MD, died Aug. 29 at the age of 95. He was the past president and last survivor of the Detroit Urological Society founders and was one of the oldest living graduates of the Detroit College of Medicine and Surgery. Before his retirement, he had specialized in problems of male infertility. Doctor Dodds was affiliated with Harper Hospital. He had been assistant professor of urology at Wayne State University and was a member of the American Urological Association.

Abraham A. Steiner, MD
Lansing

Long-time Lansing family physician, Abraham A. Steiner, MD, died Aug. 7 at the age of 68. Doctor Steiner was affiliated with E. W. Sparrow and St. Lawrence hospitals in Lansing. He had been active in civic affairs and was a member of the Ingham and Michigan Pharmaceutical Societies. He was a graduate of the Detroit College of Medicine and Surgery.

Frederick W. Tamblyn, MD
Lansing

Lansing obstetrician-gynecologist Frederick W. Tamblyn, MD, died Aug. 20 at the age of 75. Doctor Tamblyn was a graduate of the Detroit College of Medicine and Surgery and had been affiliated with E. W. Sparrow and St. Lawrence hospitals in Lansing. He was past president of the Ingham County Medical Society and was a diplomate of the American Board of Obstetrics and Gynecology.

Raymond J. Winfield, MD
Dearborn Heights

Raymond J. Winfield, MD, Dearborn Heights family physician, died June 7 at the age of 57. Doctor Winfield had practiced in Marlette where he was affiliated with Marlette Community Hospital. He was past president of the Sanilac County Medical Society and former chief of staff of the Marlette Community Hospital. He was a member of the American Academy of Family Physicians and a graduate of George Washington University.

The photo at left shows the artist's models of the new Detroit General Hospital, foreground, and Wayne State University Clinics Building, rear, scheduled for opening in September, 1978. The University Clinics Building will house primary care and specialty care services, with the necessary ancillary and support services. It will have approximately 450,000 square feet of space, be built on nine levels and cost an estimated $48,350,000. A new Health Care Institute public benefit corporation has been formed by WSU to function as the management organization for the Clinics Building. The Institute will consolidate outpatient services presently provided in the clinics of Detroit Medical Center hospitals.

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New Professional Building — 5001 W. St. Joe, Delta Township, Lansing. Quality space available immediately. Excellent location, 70% owner occupied. Still time to design your own suite. Call Collect: (517) 482-5539.

103 acres of land for sale by owner. Adam F. Ponte, D.D.S. Land is located on Merritt Road in Pittsfield Township, Washtenaw County, Michigan, immediately west of U.S. 23. Land is approximately five-eighth mile south of Pittsfield Township's "New Township Center," at Michigan Avenue and Platt Road — where the new fire station stands. Sewers extend along Michigan Avenue to Platt Road, and are projected to come one-half mile South on Platt Road toward property. Offering price: $1,750 per acre. Call (313) 475-9191 or write 220 West Middle Street, Chelsea, Michigan 48118.

ALLERGIST: Dermatology Service — VA Hospital, Allen Park, Michigan. Part-time vacancy (20 hours per week) in active, well equipped allergy clinic in GM&S hospital, Progressive program of continuing education; affiliated with Wayne State University. Salary commensurate with advanced preparation, number years of practice and attainment of recognized professional stature in medicine. In addition, we offer excellent retirement plan, liberal laws leave policy and health and life insurance programs. Contact Dr. Savoy, (313) 562-6000, Extension 698. An equal opportunity employer.

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NEEDED: Internists for the Traverse City, Oak Park, and Lansing offices of the Disability Determination Program under Social Security. Salary currently in high $30,000's plus 22% fringe benefits, including life, accident, longterm disability, and hospital insurance. Deferred compensation. Pension benefit after 10 years. No malpractice insurance required. 40 hour work week. No weekends or nights. 50 hours continuing medical education benefit. Job involves review of medical records, training and teaching, as well as some public relations. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Program, Box 30011, Lansing, Michigan 48909, OR call collect: David P. Gage, M.D., Chief Medical Consultant, (517) 373-7789.

PHYSICIAN WANTED: Vacancy for physician interested in mental retardation. This is a state institution caring for 1500 mentally retarded. Includes general hospital with ancillary services. Fringe benefits include medical and life insurance, sick leave, paid vacations, retirement, long term disability, etc. Michigan medical license required. Annual salary from $24,534 to $34,076 based on qualifications. Equal opportunity employer. Contact: Isak O. Berker, M.D., Medical Director, Oakdale Center for Developmental Disabilities, Lapeer, Michigan 48446.

STUDENT HEALTH SERVICE PHYSICIAN: Excellent opportunity to share with two other physicians in providing acute care medical services to student body of nationally recognized leader of Collegiate Vocational Education. Cultural benefits of college town with large city one hour away. Beautiful hills, streams, and lakes offer unlimited recreation. Salary determined by experience. Must have or be eligible for Michigan License. Contact Vice President Edward Linta, Ferris State College, Big Rapids, Michigan 49307 or call collect (616) 796-9971, Ext. 248. An Equal Opportunity Affirmative Action Employer.

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PHYSICIANS WANTED: LaFollette Community Hospital, LaFollette, Tennessee is seeking an emergency room physician for immediate placement. Also, in need of family practice physicians, OB/Gyn and pediatricians. Guaranteed minimum $30,000 per year. Complete furnished office building adjacent to hospital. Located in East Tennessee, 45 miles north of Knoxville. Contact: J. B. Wright, Administrator, LaFollette, Tennessee 37766. Phone (615) 562-2211.

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The community is rural, with a population of approximately 3,000, and a service area of 8-10,000, located 120 miles Southwest of Minneapolis. It has a diversified economic base, underpinned by some of the country's most productive agricultural land. It has a broad range of religious, service and social organizations.

The community currently has three general practitioners, one of whom is semi-retired, averaging 60 years of age. It has two clinics, a 34-bed hospital, a 60-bed nursing home and two pharmacies.

A surgeon and pathologists from Mankato and a radiologist from Albert Lea make regular trips to the community and hospital. Medical specialists are available at Mankato (35 miles) and Albert Lea (25 miles).

For additional information, contact: D. H. Gilbert, Wells Municipal Hospital, 400 - 4th Avenue, S.W., Wells, Minnesota 56097. (507) 553-3111 or 553-5904.

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POTPOURRI

By Herbert A. Auer, Executive Editor

Comedians, essayists, others all ask, "Where are the old-fashioned family doctors?"

But seldom quoted are the doctors who ask, "Where are the old-fashioned families?"

* * *

When physicians consider the best channels for mass communications, one must remember that of the additional time being spent now by adults with the media, they give 71 percent of that added time to television, 29 percent to radio, and less time with newspapers and magazines. Television, especially, has become No. 1 media for working women.

* * *

"The interests of the many are to be preferred to those of the few," wrote de Tocqueville. What he described as "tyranny of the majority" has been described by his contemporary, Harriet Martineau, as the American's "worship of opinion". There is a paradox in America because Americans desire both independence and a feeling of belongingness.

* * *

Ben Franklin once said: "An empty bag cannot stand upright".

* * *

Latest government statistics show that the USA has the highest per capita gross national product in U.S. dollars among the major nations. The USA figure of $6,640 compares with $6,080 for Canada, $2,300 in the Soviet Union, and $3,680 in Europe excluding Russia.

* * *

An editorial in the *American Medical News* recently did not deny critics who contend the AMA House of Delegates "is mostly just talk". The editorial countered, "The truth is, democratic policy-making bodies are not efficient. They just happen to work better than any other form of responsible government".

* * *

Doctors in the UP might want to obtain a copy of the "Upper Peninsula Health Resources Directory" from the Upper Peninsula Areawide Comprehensive Health Planning Association, 1500 W. Washington, Marquette 49855. A donation of $1.50 is requested to cover mailing and printing charges.

* * *

Sure, we might make an occasional error in *Michigan Medicine*. One of the classics happened when Supreme Court Chief Justice Harlan Fiske Stone died in 1946. The *Pensacola News* streamer at the top of page one said, "Chief Justice Stone Dead".

* * *

With new interest now on politics in this election year, MDPAC leaders declare that every doctor should spend some time working for good government because politics and government have an increasing control over doctors.

* * *

If we seem to be getting more requests from college alumni funds it's because two of four colleges are involved in some degree of financial trouble. Almost four of five private colleges and universities are reported to be either in unhealthy or relatively unhealthy financial condition. The Alfred P. Sloan Foundation was involved in the survey.

* * *

A recent national opinion survey by Yankelovich, Skelly and White found 61 percent of those surveyed favored a comprehensive national health insurance, 23 percent were opposed, and 16 percent voiced no opinion.

* * *

Recent report about Rhodes Scholars finds that no midwest school can come close to the MSU claim to fame. Of the 12 Rhodes finalists from all colleges in a six-state midwest region, MSU had 3. MSU had 4 seniors become Rhodes Scholars in the past 5 years.

* * *

MSMS President Robert M. Leitch, MD, urges doctors to "take pride in MSMS's part, and take part in the Medical Society's future."

* * *

Proposals that doctors could take a sabbatical leave like professors or that doctors could return to their medical schools for an interval are advanced by Everette Gustafson, MD, in The Oakland County Medical Society Bulletin. He is critical of CME as "Commanded Medical Education" and says, "away with regimentation." He protests the current continuing medical education requirements and says, "let's think of other ways."

* * *

Businessmen, like doctors, bemoan some of the newspaper inaccuracies. Bethlehem Steel President Frederic West, Jr., dismisses those articles by saying "Some of the reporting that gets our blood up is probably more muddled than malicious." Media Critic Edwin Diamond urges papers to put the same energy, people and time into business pages that is spent on sport pages.

* * *

"Getting things done is like mating elephants--it takes two years to get any results". So says a sign in the office of Roland Hiss, MD, of Ann Arbor.

"Opportunities for the county medical societies and MSMS have never been greater . . . Individual members must study the issues and help determine the best courses of action." See article by MSMS President Robert M. Leitch, MD, on page 598 for specific suggestions as to how.

MICHIGAN MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 11 NOVEMBER 1976

"It would appear that the team approach can work effectively" — that summation aptly explains the success of the recent negotiations between Michigan radiologists and pathologists over the Blues' proposed reimbursement method changes. For a comprehensive review of all events which led to the compromise solution, read the authoritative article on pages 614-628.

Tips for filling out the state's CME reporting form are provided on page 611 by the Michigan Medical Practice Board. Make use of this timely help.

The progress of the state's residencies in family practice, a report on the new family physician residency at the University of Michigan, and the financial plight of the Statewide Cooperative Primary Care Preceptorship program are outlined on pages 641-642 inside.

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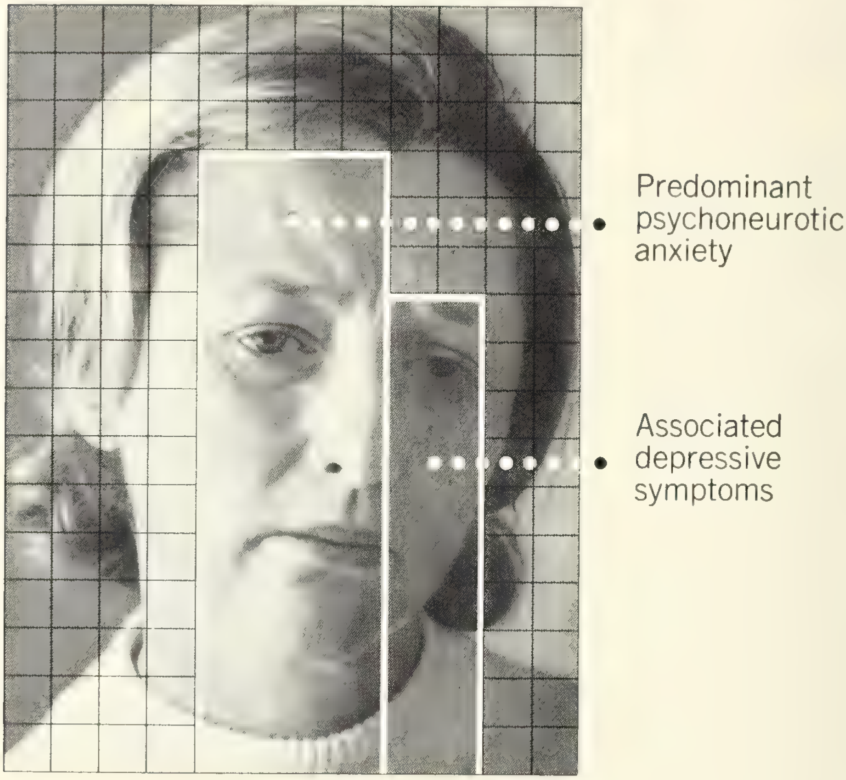
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Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue . . .

Physicians hear and read it all over — "Doctors are ripping off Medicaid. Doctors make so much money — they can foot the bill for Medicaid. And what's a little 11% cut to them?"

To set the facts straight and help physicians deal with such misconceptions, *Michigan Medicine* in its December issue will present a special article on improving public understanding of the Medicaid situation. Included are some "Points to pass on to patients . . . and others who should know about Medicaid."

Be sure to read this special article in the December *Michigan Medicine.*

Michigan Medicine Volume 75, Number 11, November 1976

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MSMS works for you, but there's much each MD can do

Robert M. Leitch, MD
MSMS President

The Michigan State Medical Society is the only society in Michigan that all the doctors can belong to.

MSMS represents every doctor in the state legislature. MSMS goes to the governor and talks for every doctor. MSMS is in the legislature seeking more funds for the medical schools so that teaching quality can continue to improve and so more students can be admitted. MSMS carries on health educational activities that benefit every doctor. MSMS represents medicine to the public. MSMS has many group insurance programs. And the mutual company benefits every doctor regardless of specialty or location.

MSMS wants to represent, work and speak for every doctor in Michigan. Let me assure you that the MSMS House of Delegates does deal with issues and does take positions, the MSMS Council and its committees implement the House decisions and work effectively on new problems, the MSMS staff is able and dedicated, working under the overall direction of The Council.

Action programs to deal with the tough questions we face are continually being developed and refined. Never before has the medical profession faced so many challenges and issues. Doctors more and more are realizing they must band together and strengthen their professional medical organizations. Lines of defense must be established. Appropriate campaigns must be planned.

The opportunities for the county medical societies and MSMS have never been greater. The need for a united medical profession is critical today. And the individual members must study the issues and help determine the best courses of action.

Let me suggest specific things every doctor can do:

(1) Learn the facts about Medicaid, chiropractic, cost containment, and then set the record straight every chance you get. Write to the newspaper. Join your local chamber of commerce. Tell one farmer your problems and listen to his. Talk to a luncheon club or a labor union.

(2) Attend medical meetings and speak up.

(3) Get active in good government.

(4) Go to meetings of the PTA and other groups and tell them about our common problems as you see them.

(5) And perhaps most of all . . . work harder to keep all the doctors of medicine united, working together on problems and solutions. Encourage new members to join. Welcome the FMGs. Keep the retired doctors in the group.

For, "Coming together is beginning, keeping together is progress, thinking together is unity, working together is success."

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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy,* Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Director

Heartbeat

By Mert Scholten
MSMS Communications Department

Fleming Barbour, MD, Flint, ophthalmologist, is new chairman of the 21-member executive committee of the University of Michigan's Presidents Club.

* * *

Paulino Chan, MD, Marshall, chief of internal medicine at Battle Creek's Community Hospital, is new president of the Calhoun County unit of the Michigan Heart Association.

* * *

Donald J. Birmingham, MD, Grosse Pointe Woods, is one of three new members of the Michigan Occupational Health Standards Commission. He was appointed by Governor Milliken in September and confirmed by the Senate.

* * *

Reed O. Dingman, MD, well-known **Ann Arbor** plastic surgeon, is recipient of Presidential Honorary Citation of the American Society of Plastic and Reconstructive Surgeons. The award was presented in recognition of Doctor Dingman's long service to the profession and his numerous academic achievements. He is a past president of the national organization and is currently professor emeritus of surgery at the U-M School of Medicine.

* * *

Arthur F. Dundon, MD, Traverse City; Charles N. Inniss, MD, Detroit and Robert W. Oakes, MD, Harbor Beach, are serving as a physician reactor panel for the Michigan Department of Mental Health following their appointment by the MSMS Council. Their role is to respond as practicing physicians to various proposals and plans of the Department of Mental Health prior to implementation or further development.

* * *

Vickers C. Hansen, MD, Manistee, in addition to his duties as a busy orthopedic surgeon is also "His Honor," the mayor of the city. He is another of a growing number of Michigan doctors who are becoming increasingly involved in active political life. He also serves as his county medical society's delegate to MSMS.

* * *

William H. Harrison, MD, Lansing, has been named by the MSMS Council to be the MSMS representative on the Department of Social Services' State Medical Care Advisory Committee. Members of the committee are to be familiar with the medical needs of low-income population groups and to participate in policy development and program administration of Medicaid.

* * *

Elwin Butler Johnson, MD, Pullman, is one 81-year-old Michigan doctor who intends to keep his medical license current. At the summer meeting of the Michigan Academy of Family Physicians, Doctor Johnson was observed not only attending the regular sessions but also spending a considerable amount of time in the Media Library self-study units earning his Category I credits.

* * *

John C. Newton, after more than 14 years with the Michigan Hospital Association, has accepted the post as executive director of Graduate Medical Education, Inc. in Lansing. GMEI is a consortium of the three medical hospitals in Lansing which, in cooperation with the MSU School of Human Medicine, offer residency training.

* * *

Joseph A. Novick, administrator for ambulatory care at Bronx-Lebanon Hospital Center in New York City, has been named administrator of the new Clinical Center, the patient wing in MSU's new $18.1 million Clinical Sciences Building. The Center held a formal opening ceremony in October and is now actively serving patients as well as serving as a training facility.

* * *

Lloyd J. Paul, MD, Southfield, is being honored this month at the Medical Profession's Division of State of Israel Bonds' Annual Dinner. Chief of staff at Sinai Hospital, Doctor Paul is the recipient of the State of Israel's Eleanor Roosevelt Humanities Award for his outstanding service to communal and Zionist causes. Members of the group help support Israel's economic development through the purchase of Israel Bonds. Last year, under Dr. Paul's leadership, physician members purchased nearly $1 million of the bonds.

* * *

Donald N. Sweeny, Jr., MD, Detroit, is currently serving as chairman of the AMA Council on Medical Service following his election to the post in August. He will serve one year as the 11-member committee's chairman. The Council oversees the work and activities of several AMA committees including those on aging, community health care, government medical services, health care financing, health care of the poor, private practice.

* * *

David VerLee, MD, Flint ophthalmologist, his wife and two of their children spent two weeks this summer in the Dominican Republic serving the medical needs of island natives. Doctor VerLee and other ophthalmologists, also allied health personnel manned daily eye clinics. Mrs. VerLee's ability to speak some Spanish came in handy in patient interviews prior to examinations. The children assisted as patient guides. *The Flint Journal* carried a full page feature story with photos of the activity following the VerLee's return.

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Flint 48503

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Flint 48504

Marcine C. Davies, MD
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Mt. Pleasant 48858

MEETINGS

(See also listing of Category I programs on page 634)

December 4-7 — 30th Clinical Convention of the American Medical Association at Philadelphia Convention Center, Philadelphia, contact: Frank Chappell, AMA, 535 N. Dearborn, Chicago 60610

December 11 — December Seminar, "Lesions of Salivary Glands," Michigan Society of Pathologists at Rackam Auditorium, University of Michigan, Ann Arbor, contact: John Dunkel, MD, MSU, Dept. of Pathology, Fee Hall, Room 677, East Lansing 48824

December 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

January 12, 1977 — Michigan Dermatological Society regular meeting at Providence Hospital, contact: Richard F. Elton, MD, 15901 W. Nine Mile Rd., Southfield, 48075

January 19 — MSMS Council MSMS Headquarters, contact: Warren Tryloff, MSMS director

January 23 — February 1, 1977 — MSMS/INTRAV Trans-Panama Canal Air/Sea Cruise, contact: Marce Ireland, MSMS Headquarters

February 12, 1977 — February Seminar, "Bleeding Disorders and Thromboembolic Diseases" sponsored by the Michigan Society of Pathologists at Henry Ford Hospital, contact: John F. Dunkel, MD, MSU, Dept. of Pathology, E. Lansing 48824

March 2 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director

April 20 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director

April 19-21, 1977 — International Symposium on "Human Ovulation" at C. S. Mott Center for Human Growth and Development, Wayne State University School of Medicine, Detroit, contact: Dr. E. S. E. Hafez, C. S. Mott Center

May 6 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director

May 14, 1977 — May Seminar, "Lymphoreticular Disorders" sponsored by the Michigan Society of Pathologists at Hurley Hospital, Flint, contact: Jacob E. Briski, MD, Saint Johns Hospital, 22101 Moross Rd., Detroit 48236

June 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director

June 18-22, 1977 — AMA Annual Convention, San Francisco

WELCOME/*Continued*

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commentary

Gulf between scientific discovery and public understanding must shrink

Doctor Kahn

(The following is reprinted with permission from the May, 1976 issue of the *Michigan Alumnus*. It was written as controversy grew concerning current U-M research involving the so-called recombinant DNA molecules.)

By Raymond H. Kahn, PhD Ann Arbor

Mankind is witnessing an unparalleled expansion in scientific understanding, particularly in biology and medicine.

Almost daily we learn of basic and clinical studies which have profound influence upon our health and well being. In the 35 years since World War II we have come to accept without question antibiotics, polio vaccine, blood banks and blood transfusion, sophisticated artificial prostheses, electronic heart pacemakers energized by nuclear energy and the contraceptive pill, to name just a few.

Predictably, biological and clinical investigations will continue to bring about new and incredible advances. In the next 35 years we can foresee a marked increase in the longevity of man, further control of reproduction, improved methods for diagnosing and treating cancer and hereditary defects, and more sophisticated insights into behavior and its modification.

Each of these major advances, existing or predictable, owes its success to the innovative approach of numerous scientists who have been able to work in a relatively free environment, supported by both public and private funds.

Much of this new knowledge has had profound social implications. For example, the advent of the contraceptive pill has given society the choice of parenthood, yielding a new era of sociosexual freedom. Undoubtedly, an increasing awareness of the consequences of the pollution that affects our environment has been largely responsible for recent legislative actions. This ability has produced problems as well. The power to influence our environment and health has led to a rapid increase in human population which poses critical dangers to the very existence of man as a species.

Social system behind

When one attempts to tabulate the number of biological problems that our political and legal system has been called upon to adjudicate, one begins to recognize that the social system has not kept up with biomedical advances. For example, consider the current interest in asbestos, abortion, artificial insemination and even the definition of death!

Probably the most newsworthy at the moment is research with recombinant DNA molecules. DNA — or deoxyribonucleic acid — is a pair of interwound molecular chains arranged to form a double helix. The DNA chains are uniquely composed and contain an extraordinary amount of recorded genetic information. In essence, the DNA molecule represents the genetic dictionary which carries hereditary information as coded units, functionally represented as the genes. It is important to recognize that the genetic units are universal. That is to say, the coded units are apparently the same for all living organisms and are based on the DNA molecule. Each species is different because of the unique array of its genetic code. The establishment of the DNA structure and the recognition of the universality of the genetic code has opened new and important avenues for research. Because species generally do not interbreed, species have had little opportunity to exchange genetic information. Since the code is composed of chemically identical, definable units of information, it is feasible to replace segments of the DNA code from one species with new combinations of information derived from another species.

The possibility of recombining information in the DNA has both beneficial and detrimental implications. On the one hand, the ability to replace hereditary units that are absent could permit the selective production of special products that are genetically absent, the repair of existing genetic defects or even a determination as to why the body rejects foreign cells, the first small step toward "genetic therapy."

Investigation needed

Obviously, this new biologic tool needs considerable basic investigation. One accessible starting point is to modify the genetic structure of common bacteria and viruses. Preliminary studies with bacterial cells have demonstrated that it is possible

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Doctor Kahn is professor of anatomy at the University of Michigan.

to chemically cleave DNA into segments and to make the cut ends sticky, permitting a segment to be "glued" to another. Moreover, the genetic characteristics of the DNA segment remain biologically active and the added DNA segment can be reproduced in the cell. By the addition of selective genes, it may be possible to create bacteria which produce specific hormones or nutrients, or perhaps degrade plastics and oil spills. Unfortunately, there exists the danger that the addition of genetic information could lead to new species of bacteria which might have properties that could make them hazardous unless they are adequately contained.

Currently being discussed at the University and considered extensively by the National Institutes of Health is the question "What criteria must be established to assure that such DNA recombinants will not be hazardous to society?" Four levels of physical containment and three levels of biological containment have been proposed by experts and by the scientists who will be directly dealing with the recombinant DNA studies. Each level has been designed to be considerably more stringent than the potential risk would seem to require. While over the years extremely dangerous bacteria have been safely contained with less stringent regulations, critics of the proposed security measure point to the possibility of human error. The prudent and reasonable approach which most scientists accept is that any new agent should be handled under conditions which provide a large margin of safety.

Benefits justified?

The current controversy is asking whether the potential benefits of recombinant DNA justify the potential risks.

However, the discussion is really addressing a larger issue, namely the balance between scientific freedom and scientific responsibility. The question being posed is: to what degree shall science be given the autonomy to continue to accumulate knowledge and how accountable must scientists be to society?

Such questions have not been confined to the twentieth century. Even Galileo was brought to trial for his unorthodox belief that the earth revolved around the sun. Less than one hundred years ago, the writings of Darwin engendered considerable disagreement over the evolution of man.

Clearly, the advancement in knowledge is a fundamental and reasonable expectation of science. Yet the means of achieving knowledge must be carried out in such a way as to provide public safeguards. In the case of the recombinant DNA methodologies, it is important to emphasize that it was a group of biologists engaged in recombinant DNA research who took the initiative and called for a temporary ban on experiments that would involve certain types of genetic manipulation. This moratorium was followed by an international meeting, again organized by scientists, in which they proposed procedures to protect against potential hazards.

Since science is inextricably intertwined with major political, social and economic problems, the scientist and society are both beginning to demand accountability. Scientists realize they can no longer afford to be naive about the social and political effects of their findings and opinions. Scientists have an obligation to keep the public aware of their research, its values, its dangers and the potential benefits and consequences. It follows that the decision-making process must be in the public forum with informed adversaries. An informed public is essential so that the scientific validity of the issue(s) are not sacrificed to emotional public debate.

U-M pioneer

The University of Michigan has been a pioneer in recognizing that responsibility. Long before the question of recombinant DNA became a public issue, Vice-President Overberger appointed one committee to decide on the containment facilities that would have to be built and a second committee was charged with determining the ethical and legal implications of such research. Moreover, a University Values Program has provided an open forum for in-depth discussions, all culminating in the Forum on Recombinant DNA held on March 3 and 4 and sponsored by the Senate Assembly Research Policies Committee.

In summary, the distance between scientific discovery and public understanding must be reduced. Equally important, the time and information lag in legislative operations must be shortened. If scientists are to continue to contribute to the advancement of knowledge, they must be able to operate with a degree of autonomy as well as adequate and predictable support. Legislative action to support science must be borne from an informed position rather than for purely political reasons.

If society is to meet and accommodate the changing world, we are going to have to encourage a different kind of political leader, individuals who understand that the issues confronting man are not always isolated, who recognize the potential of science and its implications and are willing to defend the less political decision for the long-term betterment of the human race and its environment.

(Continued on page 608)

Roerig presents a guide through the labyrinth of vertigo

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COMMENTARY/*Continued*

The very real problems of the insurance industry

What's behind your insurance agent's claims that his company has problems, too? This article, reprinted with permission of the *Detroit News*, clearly describes the problems of insurance companies trying to underwrite casualty insurance such as professional liability policies.

By Vincent R. Courtenay
Det. News Financial Ed.

The plight of the insurance companies is a dire threat to our economic well-being. Yet few citizens are willing to lend an ear to their pitiful travail.

One thing about the U.S. economy that isn't always apparent is that it is an insured economy. Business and industry cannot operate without insurance to protect them from the liabilities they must face.

We tend to envision insurers as those folks who own large office towers in the hearts of the nation's business centers. Why, some of them even have reproductions of their landmark buildings emblazoned on their insurance policies.

They are the wealthiest of the wealthy, are they not?

Actually, a lot of them are going broke.

Let's look at the casualty insurers, where the problem is crucial. Casualty insurers are those who insure against casualty loss. They provide auto insurance, homeowners' insurance, medical malpractice insurance, product liability insurance for manufacturers and so forth.

The way these firms manage to survive is by charging premiums on insurance policies that collectively provide more income than the firm must pay out in claims.

The insurers traditionally have done this by shrewd actuarial calculations. By utilizing existing casualty statistics, they are able to forecast the approximate number of claims they will get against them relative to the number of policies they write. Unfortunately for the insurance companies and fortunately for their policyholders, the actuaries are almost totally unable to predict inflation rates, either generally or in specific areas.

The result has been that premiums charged for coverage have not been nearly enough to cover claims. Claim settlements in nearly every area of liability have increased at a much greater rate than insurance premiums which cover the liabilities.

Another "inflation" phenomenon has hit the industry, too. That phenomenon is the readiness of citizens to sue heavily for damages and the trend of courts to award damages in ever-increasing amounts.

Here are some staggering statistics that show without doubt the downfall of the all-important casualty insurance industry:

Insurance companies are required by law to maintain a certain reserve of funds relative to the amount of insurance underwritten.

The surplus for the casualty insurance industry at the end of 1972 was $28.2 billion. At the end of 1974 it had plunged to $20.9 billion, a drop of nearly 26 percent in two years.

Profits give an even better picture of the plight of the industry. Industry underwriting profits in 1972 were $1.1 billion. In 1973 the industry showed just $5.76 million in profits — less than 1 percent of the previous year's level.

In 1974 the same sharp decline in underwriting profits continued. The casualty industry recorded a loss of $2.66 billion.

Losses from casualty underwriting in the first nine months of 1975 totaled a staggering $3.6 billion.

Here's how costs the insurer pays to settle casualty claims have gone up:

- From 1967 through October, 1975, the cost of auto repairs has gone up 79.5 percent, medical care costs have risen 73.5 percent, hospital charges have gone up 145.5 percent and doctor's fees have risen 74.1 percent.
- Auto insurance rates in the period have risen 48.5 percent.
- Property insurance liability items also have gone up. House repair bills have risen 91 percent, and construction costs have gone up 91.7 percent.
- Property insurance premiums have risen 34.8 percent.
- The overall cost of settling automotive claims rose 19.9 percent in the first nine months of 1975 compared to the first nine months in 1974.

(Continued on page 610)

Mr. Courtenay

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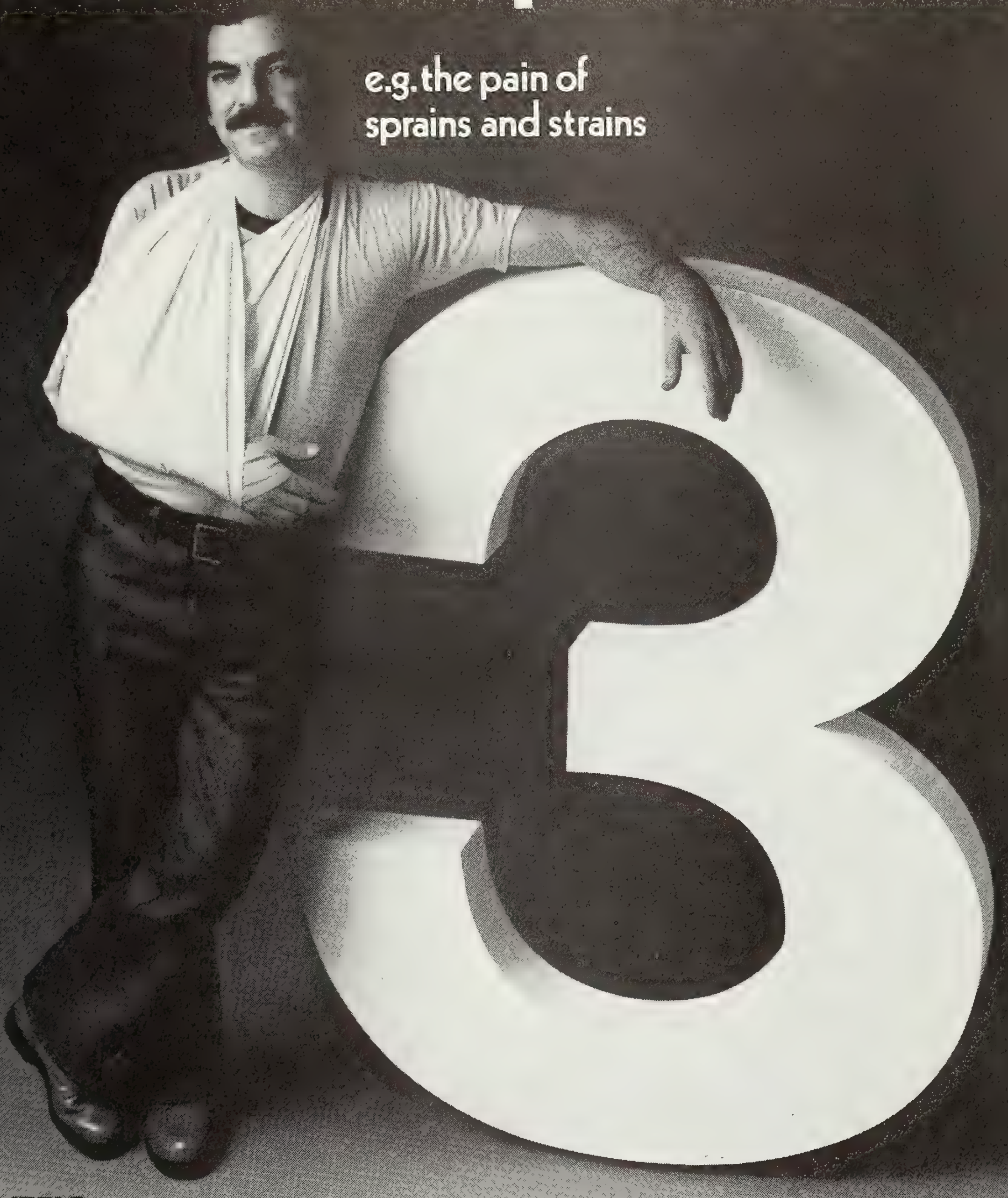

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COMMENTARY/*Continued*

Americans owe longer lives to good medical practice

By James H. Sammons, MD
Executive Vice President, AMA

(Special to Michigan Medicine)

Whenever we as doctors hear or see claims about the longevity trends in our nation, we should jump in and help claim credit for the medical profession.

The old adage that if doctors do good our public relations will be good needs to be changed. We must be more active telling people about the good we do."

Let me expand on the recent news reports about good longevity trends:

A population explosion of older people has been under way for a number of decades and the elderly are now the fastest-growing age group in the United States. Between 1960 and 1970 the aged increased by 21 percent, compared with an 18 percent increase among those under 65. In fact, the 75+ group increased by 37 percent.

Older people have become highly visible only since the nineteenth century; before then relatively few people lived beyond 65. In 1900 only three million, or 4 percent of the population, were over 65. Increased life expectancy followed medical advances in the prevention and treatment of influenza, pneumonia, tuberculosis, and gastritis, as well as generally improved public-health measures, particularly in sanitation. Lower rates of infant and maternal mortality enable larger numbers of people to reach old age and once there, new drugs and techniques allow many old people to survive once-fatal illness.

In 1900, the average life expectancy at birth was 49 years; now it is almost 71 years.

Each day of the year, about 4,000 Americans reach age 65 and about 3,000 already 65 die. Thus, the nation's planning must take account of not merely the 1,000 increase in the aged, but 4,000 a day or 1.5 million a year who are newcomers to the ranks of the aged. These newcomers are quite different from those already 80 years of age or older.

The older persons of tomorrow will be better educated and more attuned to society's problems. The aged will be less emotionally dependent on their children, more mobile, and more able to cope with changing technologies and moralities. They will have more schooling, less foreign-born, more widows, less earnings in the wage force, more years of retirement, better health in many respects, but more costly health care.

With new medical discoveries, an improved health-care delivery system and the presently declining birth rate, it is possible that the elderly will make up one-quarter of the total population by the year 2000. Major medical advances in the control of cancer or heart and vascular diseases could increase the average life expectancy by ten or even fifteen years.

INSURANCE COMPANIES/*Continued*

The increase in accident frequencies in the period was 5.6 percent.

So much has been written about the soaring cost of medical malpractice insurance, the high frequency of claims against doctors and the huge awards being made by the courts that that aspect of underwriting is already well known.

Insurance companies are canceling out medical malpractice policies, raising the premium rates in $10,000 multiples and even diverting from medical underwriting entirely.

Product liability claims also have shot up. Insurance sources say there is some danger of companies being refused liability insurance because of large or frequent claims.

Here's a development in all this which can affect every American car owner:

Insurance policies carry deductible clauses. The insured waives the right to place claims for damages that are below a certain level — say $100.

The deductible clause permits the insurance company to write its policies at much lower premium rates than it could if it insured for 100 percent liability coverage.

Often the administrative cost for the insurer of settling a small claim below $100 is greater than the claim itself. The deductible, then, cuts down administrative overhead costs drastically. In addition, it ends the payout for minor claims. The minor claim, of course, occurs at a much higher frequency than do those involving larger costs.

With inflation, with parties involved vying for insurance company settlement money, the tendency — the insurance industry says — is for damage claims to be escalated above the deductible level so a claim can be filed.

The insurance company then must settle the claim and incur both the actual liability charges and its own administrative costs.

Will the deductible levels be raised? Or will the higher cost be figured into general premium increases?

Most likely insurance companies will continue to nosedive, go broke or flounder.

The insurance firms, like utilities, are regulated. They cannot adjust rates without the approval of their regulators.

About filling out that CME form —

The January 1 deadline for Michigan physicians to report their required hours of continuing medical education is fast approaching.

In past issues, *Michigan Medicine* and *Medigram* have helped physicians understand better how to accumulate the required numbers of credits in the various categories.

Here, we will attempt to help physicians to fill out the three-page CME form, so that they may be assured of receiving credit for all necessary CME work done.

Major points to remember in filling out the form:

(1) Include your Michigan medical license number in the top right hand corner of the first page.

(2) Be sure to have the form notarized before submitting it to the Medical Practice Board.

(3) Send the forms in as soon as the necessary 25 hours of Category I credits and 25 hours of other category work are completed, to assist the board in processing the forms before the deadline rush.

(4) All credit hours must have been accumulated during the CME calendar year (Dec. 1, 1975 to Nov. 30, 1976) and cannot have been earned before that time.

(5) All credits have to have been earned through activities and courses approved by the AMA, Michigan Medical Practice Board or MSMS. No others qualify.

(6) If you have lost your copy of the form (mailed in January to every licensed Michigan physician, along with a copy of the regulations for the CME requirements) you may duplicate a form on any copy machine, or write the Medical Practice Board, 1033 S. Washington Ave., Lansing, 48926, for another copy.

* * *

Other points to remember in filling out the form:

(1) Follow directions exactly for filling out the form. The form clearly indicates what information is needed. But, in addition:

(A) Under Category III, please list the number of hours spent teaching, as well as the amount of credits earned.

(B) Under Category V, please list the amount of time spent in self-assessment, self-instruction or specialty board examination preparation, as well as the credit hours earned.

(2) Please make one general notation for hospital staff meetings, where they were held and the total credit hours earned, if you attended a number of similar hospital staff meetings for Category I credit.

(3) Please enclose a program for each Category II course cited on the form, so that the Medical Practice Board may ascertain the nature of the course.

(4) Please note that the maximum hours allowed under Category III is 16, and not 12 as was first printed on the form.

(5) Please note the maximum allowable hours under Category VI (full-time participation in a graduate training program) remain 50. Any person may receive 50 hours for enrollment in a graduate training program in a hospital or institution approved by the board. The dates of participating must occur between Dec. 1 and Nov. 30.

(6) There is no need to state that you have earned more than the maximum number of required credits in each category. 12 for Category II, 16 for Category III, etc., are sufficient notation.

(7) It is not necessary to send along verification forms or stamps for each meeting attended. The physician should keep them in his own file, in case of auditing.

(8) Please type or otherwise make as clear as possible the answers to each question.

(9) The board is unable to acknowledge whether the physician's reporting form is correct or incorrect. If no notice is received otherwise from the board, the physician can consider the form accepted, subject of course, to an audit of programs, at a later date.

(10) All physicians wishing relicensure for 1977 in Michigan must submit a reporting form or a letter seeking a waiver. Physical and mental disability waivers request must be accompanied by a letter from the attending physician.

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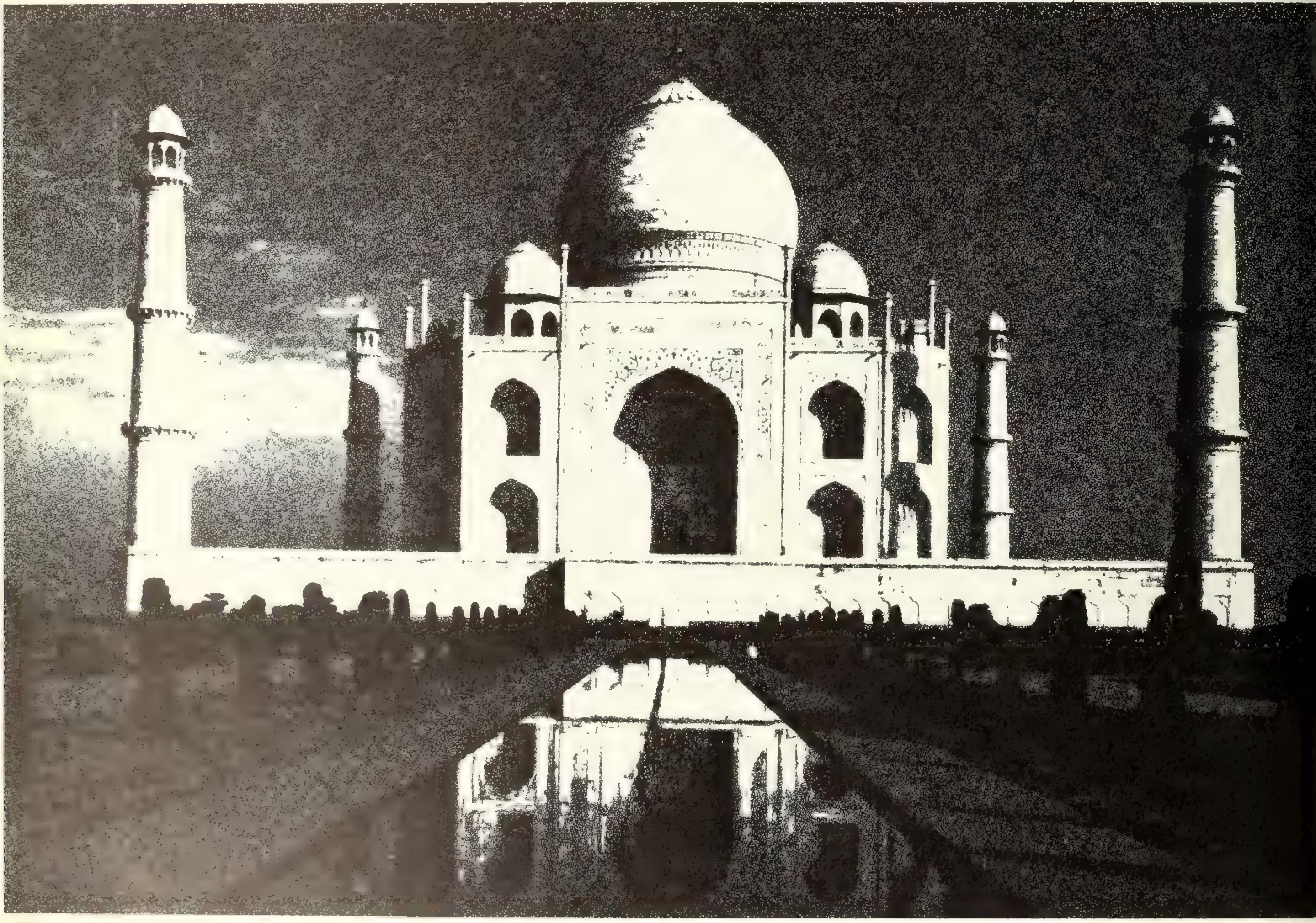

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Another Non-Regimented INTRAV Deluxe Adventure

SPECIAL ARTICLE

Michigan physicians and the Blues — a chronological report of the latest face-off

By Jean Pearson
Special to Michigan Medicine

Early this year the medical profession in Michigan found itself at another third-party crossroad — and wondered if an ambush lay ahead.

Was Blue Cross-Blue Shield of Michigan (BCBSM) going to determine not only how much a physician would be reimbursed for his services but also change his traditional method of compensation?

Though the professional struggle with BCBSM focused on radiologists' and pathologists' compensation, the Blues' "Hospital-based Physician Reimbursement Recommendations" were obviously just the first — and handiest — step toward third party control of medical service payment methods. Next handiest would be anesthesiologists and emergency room physicians. After that, could any physician be out-of-reach if he were a participating doctor?

The issue spurring BCBSM's proposed program was, and still is, admittedly serious and urgent — cost containment of health care. Like freedom, almost everyone rallies — at least verbally — to its cause. But, like freedom, cost containment also exacts a toll. In this case, it is the toll of limitation.

How should the limitation be set? By whom? Who will bear the brunt — physicians, hospitals, patients? Can an equitable solution be found?

Pinpointing the origin time is difficult.

The Michigan Insurance Bureau claims it has been hounding the Blues to shape up financially for years. The rate increase decisions of succeeding insurance commissioners bear out that fact.

The Blues claim they've been badgering physicians to do a better job of controlling medical care costs for years.

And hospital-based physicians claim they've done more to control costs through utilization review and professional educational programs than anyone else.

The initial report

If no one knows how long the pot has been simmering, at least hospital-based radiologists and pathologists know when it began to boil.

It was in August, 1975, when the staff of the Blues presented an "Initial Report on Hospital-Based Physician Compensation: Pathology and Radiology" as the result of a study requested by the Blues' Professional and Utilization Subcommittee of the BCBSM Board at its May 30, 1975, planning meeting.

The report signalled BCBSM's intent to zero in on hospital-based radiological and pathological reimbursement policies.

A BCBSM study had been made of approximately 34 percent (79) of all BCBSM participating acute care facilities. The hospitals were categorized into four bed-size groups (< 100 beds, 100-200 beds, 200-400 beds and 400+ beds.)

To provide a check on certain of the cost report data and to gather additional information not available elsewhere, questionnaires were mailed to 39 of the 79 hospitals. Twenty-nine (75 percent) replied.

In this sample, reported reimbursement arrangements included: Purchased service (found only in pathology departments); salary (found only in pathology departments); percent-of-charges (found in both radiology and pathology departments), and fee-for-service (separate billing, found only in radiology).

Of the 29 forms returned to BCBSM, 19 gave "useful comparative data," the Blues' staff said. The staff further reported 15 of the 19 indicated the average annual hospital-based physician compensation per physician on a full-time equivalent basis was $98,914. The remaining four hospitals with salaried arrangements indicated an average compensation of $68,389, or 42 percent less.

Mrs. Pearson currently is freelancing in science writing and formerly was a medical news reporter with Detroit newspapers.

Mr. Jones

"It is also interesting to note," the staff said, "that the hospitals surveyed indicated that approximately 68 percent of their pathologists received compensation from at least one other facility during the period in question."

For radiologists, the average compensation per procedure was highest under fee-for-service arrangements in three of the four bed size categories. However, physician compensation per full time equivalent was available from the survey forms for only the percent-of-charge method, the staff reported, saying "It averaged $116,648 for 10 hospitals" from which information was derived. It added that the number of radiologists receiving compensation from at least one other source averaged 72 percent.

BCBSM staff recommendations

The staff recommended that the project be continued and intensified to expand the sample size to include all BCBSM hospitals and obtain a significantly larger data base for future decisions. "The importance, of course, of a large and accurate data base to consideration of hospital-based physician compensation issues cannot be overemphasized," the report stated.

A second recommendation was that discussions be held with representatives of both the institutional and professional health care groups within the state, such as the Michigan Hospital Association and the Michigan State Medical Society, to keep them informed of the project's progress and provide the groups with "a convenient input mechanism for both additional information and identification of their particular concerns and ideas." (There was no specific recommendation for consultation with hospital-based pathologists and radiologists, the ones who would be most affected.)

The third and final recommendation was an "intensification of research efforts to identify the results of other physician compensation projects performed on both a national and statewide basis."

Enter insurance commission

Next on the scene was the insurance commissioner who always holds the key position whenever BCBSM asks for a rate increase — which it did in December, 1975.

A one-year rate increase came through in March of 1976, but not before many stinging words and sharp indictments had been made by the commissioner about the Blues' method of operation. The decision ordered some cost containment features — a 10 percent increase cap on hospital reimbursement and only a four percent increase in physician profiles except for those physicians who had not had an increase since April of 1974, when price controls went off.

Insurance Commissioner Thomas C. Jones emphasized that he only granted the rate increase to rescue BCBSM from financial insolvency, a condition which might have a chaotic impact on the medical care of BCBSM's 5.5 million subscribers.

Commissioner Jones said BCBSM had a long record of mismanagement, non-management and cost containment inaction despite its legal and moral responsibility to provide a voluntary, non-profit plan for financing health care at the lowest possible cost.

For the last eight to 10 years, he said in an interview, it has been obvious that unless the Blues took cost-containment measures, "The whole system would explode." It has now reached a highly critical explosive state, Jones claimed.

Not all of the blame for the increased rates can be placed on BCBSM, Jones said, because there has been a general increase in cost of goods and services. But he pointed out that the cost of health care in Michigan has outpaced that of the nation as a whole and, as the dominant health insurance company in Michigan through favoring legislation, BCBSM has an inescapable responsibility to contain costs with vigorously implemented programs.

When the commissioner issued a full notice of hearing on BCBSM's rate increase request, he set forth the questions to be addressed.

Item 5 was: "Should Blue Cross and Blue Shield of Michigan be required to develop and implement a cost reimbursement mechanism which prevents reimbursement for unnecessary laboratory and x-ray expenses?"

Then, on February 19, the commissioner served an amended notice of hearing which modified item 5 to: "Is the proposal of Blue Cross and Blue Shield of Michigan as set forth in their letter of January 19, 1976, and February 10, 1976, with regard to the development and implementation of a cost reimbursement mechanism which prevents reimbursement for unnecessary laboratory and x-ray expenses, a sufficient response?"

The BCBSM controversial hospital-based radiologist and pathologist reimbursement program was underway.

Three forces zero in

Perhaps the idea of cost containment through control of utilization of radiological and pathological services

THE BLUES/*Continued*

sprang independently in three different sectors; but observors noted some similarities among the BCBSM cost containment measure, Sen. Herman Talmadge's (D., GA) medicaid-medicare reform bill, and the Insurance Bureau's "1976 Program Initiative: Utilization of Laboratory and X-ray Services."

Sen. Talmadge wants to curb pathologists', radiologists' and anesthesiologists' compensation and feels the only acceptable form of percentage or lease contract is one that incorporates some kind of "reasonable" ceiling to control costs. Actually, he is reported to prefer ending all lease and percentage contracts.

The Insurance Bureau's program was concerned about utilization of all laboratory and x-ray services.

BCBSM aimed at one segment — hospital-based physicians — and zeroed in on their method of compensation as the prime cost containment mechanism.

The Insurance Bureau selected laboratory and x-ray utilization as its 1976 initiative program for a number of reasons, possibly, but in discussing the program it cited "the dramatic increase" in those "two distinct but related services."

The Bureau estimated the BCBSM paid out approximately $171 million in 1975 for laboratory and radiology services and that, at the very least, 29 percent of it was for unnecessary services paid out because the Blues did not have an effective utilization review.

Therefore the staff recommended that $50 million be deducted from the requested rates increase unless BCBSM developed and implemented "a program to overcome such wasteful expenses."

The Bureau staff reported: "We have taken the position that while the threat of malpractice claims may lead to some excessive utilization of lab (and x-ray) services, it does not appear to be a major cause of this problem. What appears to be a prime factor, however, is a lack of restraint on the part of physicians in ordering these tests."

It noted: "The chiefs of staff and medical services in all hospitals could be called upon to monitor the utilization of lab services by their physicians. This presupposes, however, that these heads of services have the support of the administrators of their respective hospitals to either contain or decrease utilization. This support will not easily be won because it is definitely known

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that hospital laboratories are one of the highest, if not the highest, revenue producing units in the hospital. Revenue (profile) from this service are used to subsidize other less profitable functions of the hospital."

The Bureau made 10 specific recommendations for BCBSM action in a cost containment program. It put a heavy weight on better data gathering and auditing on hospitals relative to laboratory and x-ray utilization.

BCBSM recommendations detailed

What BCBSM proposed in its initial recommendations May 26, 1976 to the Health Care Cost Committee of the Blue's board raised the blood pressure and hackles not only of the hospital-based physicians (a term many deplore, since they also have their own out-of-hospital practice) but also other members of the medical profession not directly involved.

Their reaction was not based solely on economic factors. Their rights to determine their own method of receiving compensation, their rights to make contracts of their own choice with hospitals and even the definition of professional medical service were at stake.

Hospital-based radiologists under the BCBSM proposal would, in future arrangements, be permitted only two methods of compensation: one, through lease arrangements of space and equipment and, two, through a reasonable compensation method.

Under the lease arrangement the radiologist would be required to maintain par status with BCBSM. If the radiologist did not want to assume the risk involved in operating the hospital radiology department or the hospital did not want to relinquish operational control of the radiology department, the "reasonable compensation method" was the only alternative.

This alternative would allow, for BCBSM reimbursement purposes, reasonable compensation paid to a radiologist under one of the current salary and percent-of-gross (or net) departmental revenue remuneration arrangements, but require that BCBSM reimbursement be made on a cost-related fee basis. Radiology services would be billed by the hospital on a DSR, subject to UCR limitations. The physician's reasonable

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County societies to select delegates by Dec. 1

Component societies of MSMS are reminded that the 1976 House of Delegates adopted on final reading only one change in the MSMS Constitution and Bylaws.

In Chapter 9, Sec. 3, a new second sentence was inserted as follows:

> The number of delegates shall be determined by the state society as of December 1, preceding the House of Delegates meeting.

This change sets a definite time when the county membership will be counted, for the purpose of determining the number of delegates to which a component society will be entitled for the next House of Delegates Annual Session.

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compensation would be included along with other hospital costs in the fee paid the hospital.

The recommendation stated "The fee screen could be initially tailored, however, to the individual facility recognizing differences in overhead costs from hospital to hospital."

In a complete turnaround on pathologists' reimbursement method, the staff recommended that "pathologists will be reimbursed on a fee-for-service basis for all services personally rendered (e.g. autopsies, tissue analyses, consultation, etc.). The professional fees will be billed on a DSR and will not include overhead costs. Reasonable overhead expense will be reimbursed on a cost basis to the hospital."

Then came the professional blow under the "other services" recommendation which stated: "All other clinical services, both inpatient and outpatient, will be reimbursed to the hospital on a cost basis. Reimbursement of the pathologist who is an employee or under contract to the hospital for supervision of clinical laboratory services will be based on a reasonable salary commensurate with supervisory (non-physician) responsibilities."

Radiologists' reactions

The May recommendations brought such a fiery reaction from radiologists, pathologists, hospitals and the medical profession that planning discussions for counter-action were held by the specialty societies. The incendiary proposals were also reviewed and given much deeper thought by both the staff and special committees or subcommittees of the BCBSM board.

Doctor Ormond

Radiologists agreed that there should be utilization controls on radiological services and there were many possible means of obtaining those controls.

But, they charged, BCBSM's proposal to control expenditures for radiological services by limiting the hospital-based radiologists' compensation method to either a "salary" (either real or in effect) or leasing arrangement was unjust and did not address the major cost problem in radiology. The problem, they said, was the ever-increasing demand for radiological services — services that have more than doubled every 10 years for the past 40.

Speaking for The Michigan Radiological Society, Robert S. Ormond, MD, and A. A. MacPhail, MD, of Flint, told the Professional Relations Committee of the Board of Directors of BCBSM that:

"It is unlikely that a radiologist could operate a major hospital department on a lease arrangement without an elastic method of compensation from BCBSM. There would be little control over services, wages and other expenditures. It is doubtful that an institution with civil service and/or union contracts could legally divest itself of its employees. Radiologists practicing in hospital departments have only marginal control over expenditures. Inflation and increasingly sophisticated procedures have escalated costs. Technologists require more training and their wages have risen, but are still considerably below the auto worker's mean wage of $12,000 per year.

"The 'Reasonable Compensation Method,' which places a radiologist on salary from the hospital, is objectionable in that it does not recognize that radiology is the practice of medicine, and that the responsibility of the radiologist is to his patient. The American College of Radiology takes the position that it is unethical for a radiologist to be on salary from an institution unless all the physicians practicing in that institution are treated equally. The 'Reasonable Compensation Method,' lends itself to exploitation of the patient and the physician."

Hospital Association reacts

Studying the BCBSM staff's May proposal, the Michigan Hospital Association (MHA) Task Force on Radiology and Laboratory Utilization concluded, among other points:

1. That the BCBSM staff paper did not specify the methodology to be followed for radiology and pathology reimbursement. As an example, the task force noted that in such critical areas as determining "reasonable" professional compensation and classification of hospital and expense components there was no reference to the proposed method (or methods) to be employed. As a result, it said, the full impact and implication of the proposal could not be determined. However, the task force pointed out, under some methods BCBSM might adopt, two or more different sets of fee screens for radiology might have to be used to determine reimbursement.

2. Before any alteration in the traditional or existing reimbursement practices for payment of covered radiology and pathology was ordered, a complete evaluation of the implications of the action should be made, including the impact on the availability of hospital-based specialist services and reimbursement to hospitals. The task force recommended that a joint study group of hospital-based specialists, Michigan Hospital Association and BCBSM be formed.

3. That though the BCBSM goal was to limit the variety of allowable reimbursement arrangements for consistency between the professional

and institutional components, it should be more concerned with the results (such as fees for radiological work) than with the variety of reimbursement arrangements.

The MHA task force also exposed some light through what it perceived to be holes in the lease arrangement for x-ray.

One, it contended, is that under lease arrangements, the radiologists would be financially responsible for the compensation of x-ray department employees who could be hired and terminated at the radiologists' discretion. However, such employees would actually be employees of the hospital and would be subject to the compensation practices of the hospital itself and not to the radiological group to whom the x-ray department was leased. This, the task force suggested, was an unreasonable, perhaps unworkable, arrangement.

Another hole, the MHA group believed, was that the financial incentive would not be enough for most physicians to enter into such an arrangement. The rental required to support the high capital investment in the radiology department would, in most cases, be almost prohibitive, the task force feared. From the physician's standpoint, the arrangement would be too uncertain financially. As a result, the MHA group thought, the hospital might be forced into subsidization or lower-than-required lease payments. Net results might be that if the institution wanted to maintain its radiological services, it would have to carry the burden.

Even if a lease arrangement could be worked out, the task force noted, the costs of doing business in radiology would increase since the radiological laboratory would be subject to property taxes.

Another hole through which the light glared was that the lease arrangement would remove significant hospital services from the direct control of hospitals though the hospitals would be responsible to assure such services were provided. The entire service program of the hospital, furthermore, could be jeopardized by mismanagement of the x-ray operation by a lessee.

The MHA group not only deplored BCBSM's proposal to pay a pathologist on two different scales on the basis that it was an attack upon a physician's role in the medical specialty of pathology, but also because it ignored the nature of the labor market. Again, the task force saw the possibility of hospitals being forced to subsidize the difference between the BCBSM reimbursement they received and compensation that would have to be paid out.

Pathologists' concerns

Hospital-based pathologists were also greatly concerned. Certainly they were dismayed that services they provided through their medical specialty of pathology were being divided into two categories — professional and supervisory — and paid out different rates.

It seemed so preposterous to them that they almost ignored it in their objections, which included the observation that the Michigan Society of Pathologists had not been presented with any evidence that the method of reimbursing pathologists had any bearing on the per unit cost or per case cost of pathology services in hospitals. Of probably far greater influence on the cost, they said, was the size, area, teaching variations, hospital, attending physician practice patterns, and hospital accounting procedures.

The pathologists declared that the nature of contractural relations between hospital and hospital physicians should not be determined by

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THE BLUES/*Continued*

any third party. Further, they said, the proposed amendments were clearly intended to determine how much they would be paid and not just how. They considered such decisions as an infringement upon the practice of medicine.

While the proposed reimbursement changes were aimed at hospital-based physicians, the pathologists noted they had far less control over utilization of pathology and x-ray procedures than the majority of physicians — the attending physicians who remained unaffected by the proposed changes.

The pathologists said an investigation should be made to determine if there was an excessive ordering of tests by attending physicians. They suggested that if there were, it might be related to many factors, including lack of understanding of test results, fear of legal liability for tests not done and lack of concern for the cost of the procedures.

The pathologists suggested that a one-year, retrospective, Michigan study of ideal utilization by medical criteria for representative diagnoses be conducted by a non-profit organization financed by the Blues and with the protocol to be agreed upon and applied by the Michigan Hospital Association and the Michigan Society of Pathology (and Michigan Radiological Society if it wished to participate).

Their suggestion had several provisos, including that the results be published publicly and that no individual or organization be penalized for participating in the study or in applying the results. In essence, if the study showed under-utilization, individuals and organizations would not be subject to screens or limitations denying remuneration for approach to the optimal.

BCBSM moratorium

On June 9, the BCBSM board of directors placed a moratorium (which had been recommended by staff earlier) on any changes in hospital arrangements with BCBSM, effective July 1, 1976, and continuing until September, 1976. (Radiologists who had not done so in 1975, were rushing to the separate-billing arrangements before any restrictive deadlines might be announced.)

The board's second action was appointment of an Ad Hoc Committee of BCBSM which would report to the BCBSM Health Care Committee by September, 1976, with a proposed solution to the high cost and utilization problems involving both radiological and pathological services.

BCBSM presents alternatives

A brief discussion of several alternative approaches to BCBSM professional services reimbursement under separate billing arrangements was presented by the staff July 14. The paper also expanded on the study presented by the staff in August, 1975.

A majority of new data and recommendations were based on medicare cost reports for 200 BCBSM participating hospitals.

The four separate billing alternatives, in slightly abbreviated form were:

1. Curtail further expansion of the separate billing program; that is not to permit additional hospitals to separately bill professional services. As a second step, require that all hospitals currently "split-billing" revert before the end of their next cost reporting period to a single billing mechanism for both facility and professional services. Hospitals continuing to split-bill after this transition period would be subject to a reimbursement penalty in recognition of the higher cost of this billing arrangement.

2. Allow a continuation of split-billing arrangements and require not only that the hospital component be settled at cost but, in addition, that the professional fees be related to actual physician cost and reasonableness procedures.

3. As a deterrent to further expansion of the split-billing program, commit all to a reimbursement arrangement whereby those hospitals (not presently split-billing) which are precluded from recovering the full reasonable cost of covered pathology and radiology services will be reimbursed the difference between their cost and what would ordinarily be considered BCBSM liability under current cost reporting procedures.

4. Continue the split billing program but establish consolidated screens which would apply to combined hospital/physician amounts claimed for BCBSM-reimbursement (i.e. hospital costs derived from the cost reporting process and billed professional fees).

The staff paper said: "It is anticipated that these alternatives would apply not only to radiology services (and other electromodalities), where the vast majority of split billing arrangements are found, but to laboratory services as well."

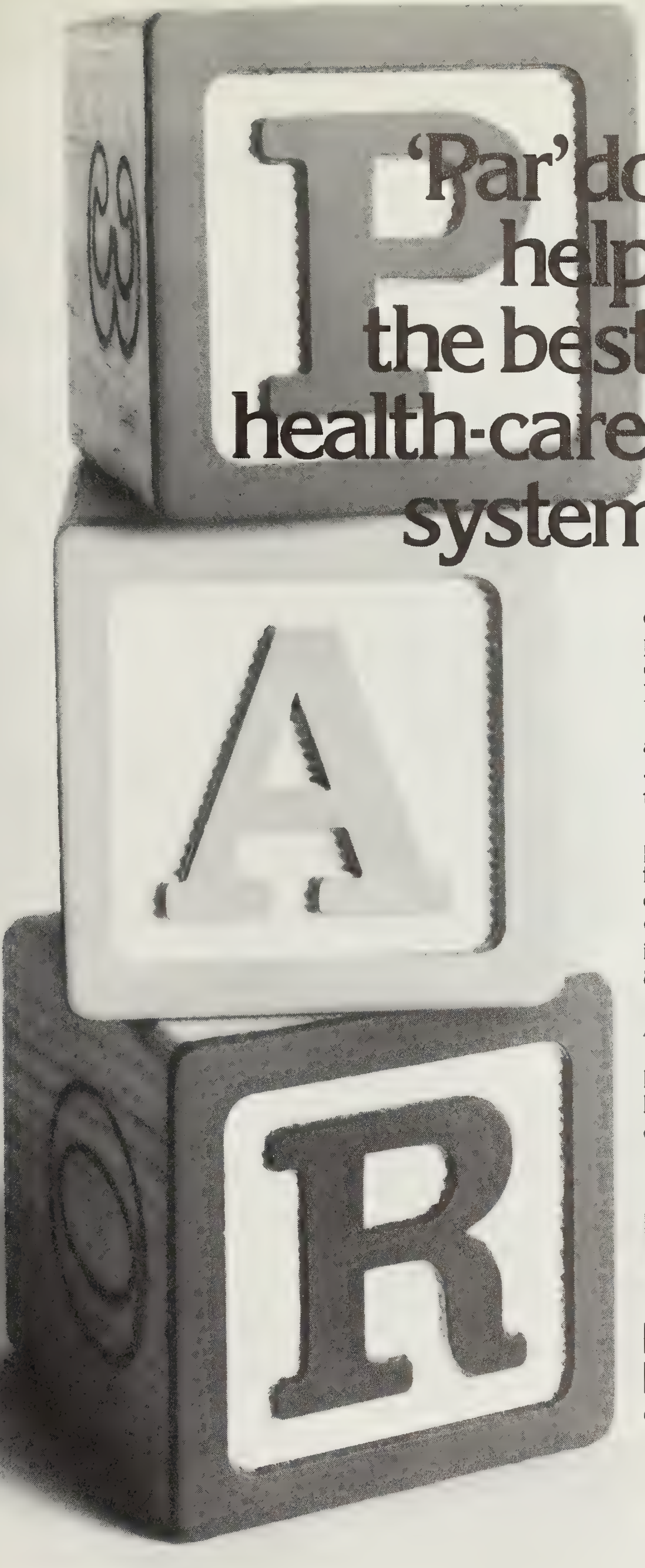
The concept of split-billing arrangements for laboratory services was still alive, although the paper did not say this time that the pathologists would be paid different rates for personal and supervisory services.

Other arrangements considered were percent-of-charges ("Physician compensation, all things equal, is generally significantly higher under the percent-of-charges method than salary arrangements") and salary ("It is often argued that the salary arrangement not only provides the hospital the greatest control over physician activities but, in addition, generally results in lower physician expense.")

A new note was the suggestion of "annual disclosure." The staff stated:

"It might be argued that one simple, but effective way of focusing more attention on the physician compensation problem is to require that annual disclosure be made to each hospital board by hospital administration and/or the medical staff with respect to compensation paid each staff physician. In those cases where a physician bills direct, perhaps in part to obviate such disclosure, BCBSM would report to each hospital the professional fees generated in that setting by each staff physician. This information would then serve as a basis for board disclosure, perhaps making more poignant physician compensation issues of which certain boards may not be fully aware."

(Continued on page 622)



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THE BLUES/*Continued*

BCBSM philosophy

Lewis M. Anderson, BCBSM group vice president for administration, said in an interview that when research on health care benefits is done, three key elements must be considered: one, quality ("everyone wants the best"); two, availability, and three, cost.

In the past, he said, BCBSM had concentrated in obtaining high quality and ready availability and let costs go where they would. But costs kept spiraling upward and it became obvious that the cost factor demanded equal attention.

Anderson said a physician advised him that you can't have all three elements at optimum — two were possible but not three. To have all three at optimum, he said, you must redefine all three.

When it comes to the question of why costs are spiraling and how they can be contained, Anderson said, everyone points to the other fellow.

Hospitals, he observed, say the costs are going up because the big buyers (UAW) keep asking for more benefits. The big buyers, Anderson noted, say it is the providers (both physicians and hospitals) who are responsible. And physicians, he continued, say that the problem emanates from the fact that subscribers are generating increased usage.

"Everyone is right, as every area is responsible for some of the rising costs." Anderson said: "What is wrong is that no one has any feeling of responsibility for it."

BCBSM strategy in containing costs of radiological and pathological services was to focus control at the hospital level, have pressure placed on radiologists and pathologists and then have them get together on utilization and attending physicians.

"Ultimately," he said, "the attending physician must be accountable."

BCBSM background

Robert Asmussen, in charge of BCBSM reimbursement policy development under Daniel J. Kehoe, group vice president for provider affairs, said in an interview that the dramatic increase in health care costs "is driving everyone up the wall."

Two forces made BCBSM look closely at all of its operational policies. They were the consolidation of Blue Cross and Blue Shield of Michigan into one corporation and great pressure for cost containment.

"We developed two objectives," Asmussen said. "The first was to develop a consistent and uniform policy to relate to our consolidated state and, second, to provide the maximum cost containment potential."

When the BCBSM Board's Health Care Cost Committee was formed nearly two years ago, he said, it looked at unit cost and utilization of ancillary services (of which radiology and pathology were the largest) and "it became clear there was a lot of room for improvement."

The committee, he said, asked staff for more information and studies. The staff decided to break the problem down into unit cost and utilization and reimbursement. It also decided to work on them separately but concurrently, realizing that utilization "was much stickier and would take longer," Asmussen added.

Changes in Blue Cross and reimbursement policies in 1967 followed by additional changes in 1975, resulted in many radiologists shifting from compensation through single billings to split-billing.

The staff, conducting its study for the committee, noted the substantial increase in separate billings.

"As a consolidated corporation," Asmussen said, "we didn't believe there was any reason for two billings to one institution." A billing costs $2.99 per claim," he explained, "and while the amount may seem small, the volume of claims is large."

In pathology, Asmussen said, BCBSM has never had separate billing. "The problem there," he stated, "was the size of income related to professional service." Asmussen said only about 10 percent of the activity was related to a pathologist's "professional service as a physician" and that 90 percent was clinical work done by laboratory technicians.

So BCBSM "took the Talmadge Bill concept" and said it would only reimburse pathologists at an administrative rate — not at the physician rate — for supervisory service in the laboratories.

Louis F. Hayes, MD, BCBSM group vice president for professional affairs, said in an interview that he personally sees some logic in basing a pathologist's compensation upon the nature of the service provided — whether it is as a "hands-on physician" or as an administrator in charge of a laboratory.

"I know it is distasteful (to pathologists)," he notes, "but there is a lot of distastefulness in verities."

Pathologists perform many services in which they are personally involved, such as autopsies, tissue studies and consultation, Doctor Hayes said, but the modern pathology laboratory is a large scale operation with a lot of technicians, some biochemists and biophysicists, and "it is, in a sense, a kind of production line activity."

"But the pathologist," he said, "is not personally involved in everything that is done. It is a supervisory role — a medical supervisory role. It has many similarities to the job I have here, which doesn't say I am rendering a personal service to every employee and that service could be classified as a medical service.

"The situation is just that simple an analysis and perhaps that's the trouble — it's too simplistic an analogy." But a medical supervisory role is not a "hands-on" personal practice of medicine, Doctor Hayes said, and therefore, possibly should be reim-

(Continued on page 627)

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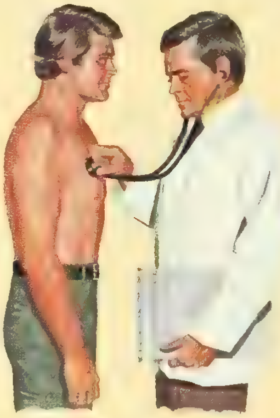
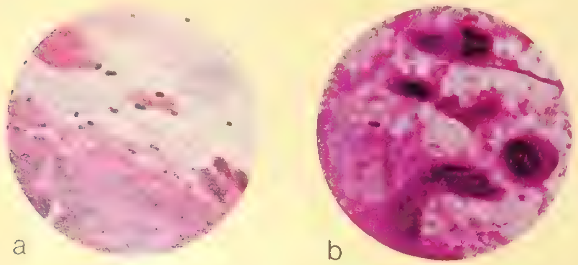


Bacterial pneumonias may have a sudden onset with a shaking chill, rapid development of fever, pleuritic pain, and cough productive of rust-colored sputum. The Gram-stained sputum smear generally shows polymorphonuclear neutrophils as well as a predominance of the causative organisms. These are likely to be *Streptococcus pneumoniae,* still by far the most frequently encountered agent in bacterial pneumonia.[1] The CBC reveals marked leukocytosis with a shift to the left.

In *nonbacterial pneumonias*—mycoplasmal or viral—classical symptoms tend to develop more slowly, with myalgia, lassitude, and headache predominating. Sputum production is usually scanty, and the sputum smear is relatively uninformative, showing gram-positive cocci and other organisms which are part of the normal pharyngeal flora. The leukocyte count is normal or slightly elevated.



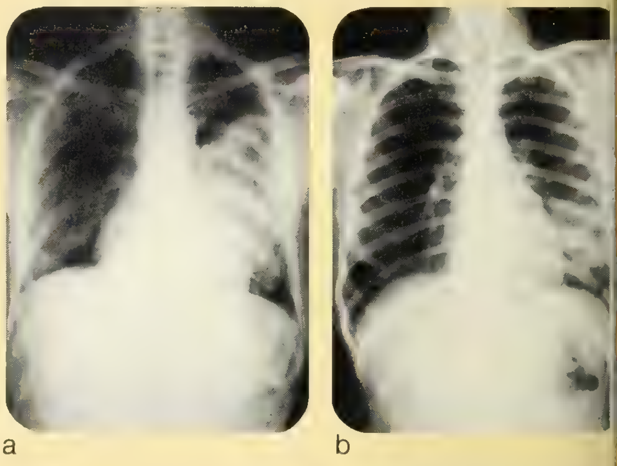
Direct Gram-stained sputum smears. (a) Pneumococcal pneumonia—note abundant polymorphonuclear leukocytes, as well as gram-positive diplococci. (b) Nonspecific—consistent with viral or mycoplasmal pneumonia. Note large mononuclear cell, as well as a few polymorphs and mixed bacterial flora (pharyngeal contaminants).

Mycoplasmal or viral?

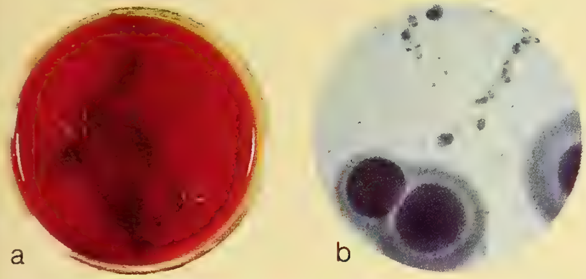
Differentiation between mycoplasmal and viral pneumonias may be impossible in the acute stage.[2]

Serologic testing and culture methods for *Mycoplasma pneumoniae* are complex and time-consuming, taking as long as two weeks after obtaining samples. The sensitivity and specificity o the test for cold agglutinins have been questioned. The complement-fixing antibody test may reflect previous infection. Furthermore, facilities for culturi *M. pneumoniae* are not widely available.[3]

If treatment is to be initiated, therefore, it may be necessary to start on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.[1-3] In reachin such a diagnosis, the physician relies on clinical judgment, considering such factors as the age of th patient and the history of exposure. For example, *Mycoplasma pneumoniae* is considered the most common cause of pneumonia among ambulatory patients aged 20 to 35.[1]



Chest x-rays of patients with (a) pneumococcal pneumonia—classically heavy, extensive infiltration of left lung;
(b) mycoplasmal pneumonia—mild infiltrate confined to left lower lobe. Roentgenography usually does not help in differential diagnosis, since both types of pneumonias may present with a wide spectrum of x-ray as well as clinical findings.



(a) Distinct mucoid colonies of type 3 pneumococci *(Streptococcus pneumoniae)* on sheep blood agar showing greenish discoloration (alpha-hemolysis) of medium. (b) Typical "fried-egg" colonies of *Mycoplasma pneumoniae* consisting of dense central core with lighter periphery. Cultural and serologic methods for detecting *M. pneumoniae* are complex, time-consuming, and not widely available.

Expectant therapy

n the patient with a presumptive diagnosis of mycoplasmal pneumonia or bacterial pneumonia, it may be desirable to initiate antibiotic therapy before culture and sensitivity results are available.

A course of erythromycin or tetracycline is considered effective in the treatment of mycoplasmal pneumonia to help speed the clearing of infiltrate and shorten the duration of symptoms.[1,3] In pneumococcal pneumonia, erythromycin is an effective alternative to penicillin, the drug of choice. A recent report, based on data from 200 hospitals of 100 beds or more, found 98% of *S. pneumoniae* sensitive *in vitro* to erythromycin.[4]

Among these therapeutic agents, only erythromycin provides effective coverage of both *Mycoplasma pneumoniae* and *S. pneumoniae*. The penicillins are not effective against *Mycoplasma*, and *S. pneumoniae* has shown a relatively high incidence of resistance to tetracycline.

When erythromycin is selected for therapy, E-Mycin (erythromycin enteric-coated tablets, Upjohn) is a good choice. E-Mycin is administered and absorbed as active erythromycin base, and may be taken q.i.d., q 6h, or b.i.d., immediately after meals or between meals. Thus, patients can use mealtimes to help them remember their medication. The enteric coating on E-Mycin tablets helps ensure efficient absorption in the intestinal tract, and bioavailability studies show that E-Mycin can be expected to produce predictable, acceptable blood levels. The low cost of E-Mycin helps assure economical therapy.

E-Mycin rarely causes serious side effects and is not associated with liver toxicity.* The most frequent side effects are upper gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. Serious allergic reactions, including anaphylaxis, have rarely been reported.

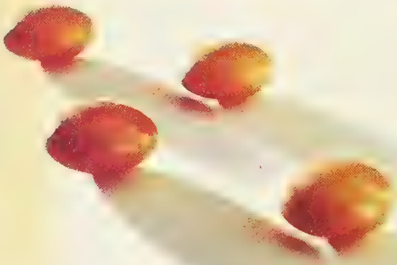
*Use cautiously in patients with severe liver impairment.

Summary

Because pneumonias may be difficult to differentiate at the outset, treatment is often initiated before a causal diagnosis is made. However, readily available diagnostic criteria occasionally allow early differentiation between bacterial and nonbacterial pneumonias. When the diagnosis appears to be nonbacterial pneumonia, further differentiation between mycoplasmal pneumonia and viral pneumonia is more complex and time-consuming. Therefore, therapy is often initiated on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.

Erythromycin is an effective antibiotic against *Mycoplasma pneumoniae, Streptococcus pneumoniae,*† and *Streptococcus pyogenes.*† E-Mycin (erythromycin enteric-coated tablets, Upjohn) is administered and well absorbed as the active base, may be taken immediately after meals or between meals, and is essentially nontoxic.

†Although penicillin remains the drug of choice against these organisms, erythromycin is an effective alternative.



E-Mycin® 250 mg

erythromycin enteric-coated tablets, Upjohn

wide-ranging usefulness in pneumonia*

*Mild to moderately severe, due to susceptible organisms.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001, U.S.A.
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REFERENCES: 1. Chusid EL, Dalrymple W, Holloway WJ, et al: Managing the infectious pneumonias. *Patient Care* 9:122-167, 1975. 2. The occasional might of mycoplasma. *Emergency Med* 7:82, 85, 1975. 3. Stevens DA: Viral and Mycoplasma pneumonias. *Postgrad Med* 55:81-86, 1974. 4. Data source: PMR Bacteriologic Report, Winter Series 1975-1976. Data are a compilation of laboratory reports submitted during December 1975 and January and February 1976 by 200 acute care hospitals of 100 beds or more.

Please turn page for brief summary of prescribing information.

Wide-ranging usefulness in pneumonia*

E-Mycin® 250 mg

erythromycin enteric-coated tablets, Upjohn

Upjohn

- For mild to moderately severe infections due to susceptible organisms that commonly invade the respiratory tract
- Essentially nontoxic (see Precautions and Adverse Reactions below)
- Documented bioavailability
- May be taken immediately after meals or between meals
- Active base formula produces predictable blood levels
- Formulated for quality...priced for economy

E-MYCIN® TABLETS—250 mg—For Oral Administration (erythromycin enteric-coated tablets, Upjohn)
E-Mycin Tablets are specially coated to protect the contents from the inactivating effects of gastric acidity and to permit efficient absorption when administered either immediately after meals or when given between meals on an empty stomach.

Indications: *Streptococcus pyogenes (group A beta-hemolytic streptococci):* Upper and lower respiratory tract, skin, and soft-tissue infections of mild to moderate severity. Parenteral benzathine penicillin G is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever. When oral medication is necessary (because the parenteral route is contraindicated) or if there is known allergy to penicillin, the following recommendations made by the American Heart Association apply: 1) Oral penicillin G or V (where no allergy exists)—This is the drug of choice. Give for a minimum of 10 days; 2) Erythromycin—Give for a minimum of 10 days. A few strains of streptococci resistant to erythromycin have been reported.
Alpha-hemolytic streptococci (viridans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.)
Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.
Diplococcus pneumoniae: Upper respiratory tract infections (eg, otitis media, pharyngitis) and lower respiratory tract infections (eg, pneumonia) of mild to moderate degree.
Mycoplasma pneumoniae (Eaton agent, PPLO): In the treatment of primary atypical pneumonia, when due to this organism.
Treponema pallidum: Infections due to this organism.
Corynebacterium diphtheriae and *Corynebacterium minutissimum:* As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.
Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extraenteric amebiasis requires treatment with other agents.
Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.
Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.
Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.
Treatment of overdosage: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdosage should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug, in addition to all needed supportive measures.
How supplied: 250 mg enteric-coated tablets—in bottles of 100 and 500 tablets, and in unit-dose packages of 100 tablets. Caution: Federal law prohibits dispensing without prescription.

For additional product information, consult the package insert or see your Upjohn Representative.
NAS-4

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*Mild to moderately severe, due to susceptible organisms

Doctor Wylin

Doctor Songe

Doctor Hayes

bursed in a different way than "hands-on" personal practice. However, he added, BCBSM had backed off from that viewpoint expressed in its original recommendations.

In their proposals, Doctor Hayes said, BCBSM was trying to place hospitals in the "prudent buyer" role to control the cost of radiological and pathological service utilization.

Specialists' reactions "vigorous"

Asmussen called the specialties' reaction to stopping separate billing for radiologists and the new reimbursement method for pathologists "fierce." Another description, as viewed from the sidelines, was "vigorous."

On July 27, 1976, attorneys Paul R. Trigg, Jr., and J. Kay Felt sent a letter to John C. McCabe, BCBSM president, stating that the Michigan Radiological Society and its members had asked their firm of Dykema, Gossett, Spencer, Goodnow and Trigg for legal assessment of the proposed BCBSM changes recommended for reimbursement of hospital-based radiologists' services.

"In our veiw," the letter stated, "the moratorium that has been instituted is in derogation of the rights of the physicians under general principles of contract law, constituting a denial of due process and, in fact, constitutes an indirect violation by BCBSM of the statutes and regulations applicable to the medicare program in that the relationships between physicians and hospitals will necessarily be affected by this unwarranted action, not only in relation to BCBSM subscribers, but also in relation to every other patient who receives service in an affected institution."

The letter detailed the reasons for the attorneys' opinions and objectives raised by radiologists to "advise you of the seriousness of BCBSM action," to request a lifting of the moratorium and to request reconsideration of BCBSM's action.

There was no immediate response and the moratorium was not lifted.

Robert A. Songe, MD, chairman of the Ad Hoc committee of the Michigan Radiological Society, said in an interview that BCBSM proposals were "an extremely simplistic answer to a complex problem" and that they were aimed at the wrong group — hospital-based physicians — instead of those who order the majority of the tests — attending physicians.

The radiologists' main objections, he said, were that the recommendations had been developed without consulting practicing radiologists and the solutions offered had no relationship to cost containment.

Robert F. Wylin, MD, chairman of the Medical Care Insurance Committee of the Michigan Society of Pathologists, said in an interview that the type of contract a radiologist and pathologist has with a hospital has no significant relationship to the cost of utilization and "we believe the reimbursement method is a legal contract that should be at the discretion of the hospital and physician."

"We have never said that one way is better than another," he said. "At a university hospital a salary might be more realistic and in other hospitals, a percentage."

Pathologists, he said, are seldom in direct contact with a patient and, though "we are sort of the doctor's doctor, we may not even see the doctor."

The possibility of doing a pathological service utilization study to get reliable data was suggested, he said, "because we don't believe that anyone has shown there are a lot of unnecessary laboratory procedures done in hospitals. There may be underutilization."

Even if standards could be set for different diseases and diagnoses, he said, pathologists aren't certain they would contain costs or save money.

The standards could be used for utilization review, Doctor Wylin noted, but the cost of revealing cases of overutilization might not be worth the finding. He cited, as an example, the experience of one hospital which surveyed 9,500 hospital charts and found six patients in which there had been overutilization of services. "The cost of identifying those six was $35,000 per patient," he said.

"We might eliminate overutilization for a few patients but the cost might be great," Doctor Wylin said. "That's what we are talking about — would it be cost effective?"

Doctor Wylin noted that pathologists are already doing utilization review work in teaching physicians and medical students how to order tests on a cost-effective basis.

"My own feeling," he said, "is that within the hospital we are controlling utilization of laboratory services pretty well."

Non-participation considered

In the pathologists' efforts to veto BCBSM's recommended changes, Doctor Wylin said, "litigation would be the last thing we'd do. But non-participation would be a move."

"The enabling legislation for BCBSM," he reminded, "requires a minimum number of participating physicians. If a sufficient number of doctors dropped participation, it would require a reorganization of BCBSM.

"This is a serious consideration, as we would be talking about the reorganization of a third-party organization. But, it is one of the few ways we have as physicians to control what has been going on in Blue Shield."

Pathologists, he reported, had responded well to the Michigan State Medical Society's collection of signed proxies for non-participation to be held in escrow.

New recommendations

A revised, less demanding set of reimbursement recommendations for hospital-based physicians in radiology and pathology was unveiled August 12, 1976 by BCBSM staff.

It recommended that three physician compensation methods be allowed (fee-for-service, percentage of gross or net charges with a ceiling, and salary). Further, it recommended that all radiology and pathology services provided by a hospital patient (both outpatient and inpatient) be billed by the hospital and cost reimbursed by BCBSM.

Methods for unit cost containment were also discussed and a new section on methods for utilization cost containment added. It included establishment by the hospital of a data base and utilization standards, a physician education program on the cost-benefit aspects of the services, and physician sanctions "for attending physicians who chronically fail to heed the utilization standards."

There was no further mention of dividing the pathologists' service reimbursement into personal and supervisory components. The pathologist was a whole, professional medical man again.

The conclusion

Another letter from the Michigan Radiological Society's attorney, J. Kay Felt, was sent to BCBSM on behalf of the society's members August 19. It discussed specific objections to the new recommendation and, once more, requested immediate lifting of the moratorium on initiating separate billing.

Again, there was no immediate response — nor lifting of the moratorium.

On September 8, Doctor Songe sent Doctor Hayes a copy of a resolution unanimously approved by 200 members of the Michigan Radiological Society attending a meeting September 2. It stated:

"There shall be no implementation of any utilization review program or suggestions to Blue Cross-Blue Shield of Michigan until the moratorium is lifted. When the moratorium is lifted, the society will immediately be prepared to sit down in meaningful discussion regarding utilization and review programs.

"If the moratorium is not lifted, the society and its members will immediately join litigation to enjoin the continued application of the moratorium and individual members will consider non-participation."

In his answer to Doctor Songe, September 13, Doctor Hayes said he was surprised at "the ultimatum" and "concerned about the impact that such an ultimatum could have on the deliberations of the Health Care Cost Committee of our Board and the Board itself."

He also said: "For your information, an Ad Hoc Committee has completed its deliberations and has developed a recommendation to the Health Care Cost Committee; the latter committee will meet September 22 to develop its recommendation to the Board for its meeting of September 29. In view of the ultimatum of the Michigan Radiological Society, I see no need to divulge to you the nature of the Ad Hoc Committee's recommendation."

The recommendations, however, were much more in line with what the radiologists and pathologists sought.

All pathology services provided a hospital patient (both inpatient and outpatient) would be billed by the hospital and cost-reimbursed by BCBSM. Two compensation arrangements would be allowed "with limitations based on reasonableness" — percent of charges (gross or net) and salary. Purchased service and lease arrangements would continue as allowable methods, billed and reimbursed "in accordance with existing policies."

For radiologists, both combined and separate billing would be allowed. If the separate billing option were selected, the hospital component would be billed on the institution billing form and reimbursed at cost by BCBSM. The physician component would be billed on a DSR and reimbursed on a usual, customary and reasonable (UCR) fee-for-service basis by BCBSM. Some policies for separate billings were also recommended. Further, new requests for separate billing would be honored beginning October 1, 1976 (the original moratorium had a "September, 1976" termination). In addition, lease arrangements would continue as an allowable method, billed and reimbursed in accordance with existing policy.

Having returned pretty much to status-quo on reimbursement methods for compensation of hospital-based radiologists and pathologists, the new BCBSM thrust for cost containment focused upon utilization of radiology and pathology services with several recommendations for annual utilization reviews.

The Ad Hoc Committee's recommendations were accepted in essence by the Health Care Cost Committee and ultimately, September 29, by the BCBSM Board.

In announcing the board's action, McCabe said:

"Based on the months of hard work invested by our staff, our board, hospitals and physicians in this program, it would appear that the team approach can work effectively."

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MEDICO-LEGAL

'Direction and control' defined in guiding physician assistant

*(Editor's note: From time to time, **Michigan Medicine** will publish excerpts of legal opinions prepared by MSMS Legal Counsel A. Stewart Kerr, Detroit. The following offers his thoughts on certain activities of physicians' assistants, and should be helpful to all physicians considering employing or currently employing assistants. This material is intended only to inform and should not be used to resolve legal problems.)*

The Michigan statute attempts to define the boundaries within which the physician-assistant may legally act. MCLA 338.371 Sec. 1 (c) provides as follows:

> " 'Physician-Assistant' means a person who is qualified by training, education or experience to perform selected acts or functions in the practice of medicine or osteopathy under the direction of a physician licensed pursuant to . . . (statutes cited) . . . Notwithstanding those acts, a person qualified by training, education or experience may perform selected acts or functions in the practice of medicine or osteopathy under the direction and control of a licensed physician."

Any physician wishing to learn more about the role and use of a physician's assistant is invited to write for a copy of a new brochure put out by the Western Michigan University's Physician's Assistant Program. The booklet explains a PA's training, role and function. Contact Mary Hawthorne at Western Michigan University, Kalamazoo, 49001.

Some physicians' questions raise issues as to the meaning of "selected acts," "under the direction and control of " and the "training, education and experience" contemplated by the Act. Certainly, this statute provides little objectivity regarding these points.

The Governor's Advisory Commission on Physicians' Assistants will develop criteria for the education and training leading to appropriate qualifications, and the "selected acts" will undoubtedly be developed as the qualifications are developed. The word "direction" was substituted for the word "supervision" in the initial draft of the legislation. This was done in order to comply with the Attorney General opinions in the 1960's holding that the word "supervision" meant physical presence, whereas the word "direction" meant something less. The rulings were used in the analysis and drafting of the Nursing Practice Act which prescribed concepts and language similar to the Physician-Assistant statute.

Based upon this background, we note:

1. The physician-assistant must be under the direction and control of a licensed physician. This means that the physician-assistant may not function independently and without consultation with a physician.

2. The physician's presence may be required depending upon the circumstances and the function being performed by the physician assistant.

3. We do not think that the broad grant of authority to prescribe drugs is included within the "selected acts" contemplated by the statute for execution by the physician assistant. It might well be that certain prescriptions would fall within "selected acts," but we feel certain that this would have to be carefully controlled by the physician and would have to be determined by the particular circumstances involved, to wit: the nature of the ailment, the patient and the drugs involved.

The newness of the Act and the flexibility given to the Commission under the Act make it virtually impossible to come up with any hardfast rules. As is the case with most general questions in the medical practice area, any definitive opinion must be controlled by the facts of the particular situation.

As a final note, Judge Horace W. Gilmore, one of the better judges on the Wayne County Circuit Court bench, recently rendered an opinion to the effect that the words "direction and control" did not require physical presence. This opinion arose out of a criminal prosecution of a graduate of a medical school in the Philippines, who was not licensed to practice medicine in the State of Michigan.

Cases reported in recent issues of the AMA's Citation

"Breach of contract for pharmaceutical services"
Michigan Court of Appeals, Feb. 10, 1976
from *The Citation,* Vol. 33, No. 9

"Patient fails to establish standard of care"
Michigan Court of Appeals, Dec. 4, 1975
from *The Citation,* Vol. 33, No. 9

"Physician not liable for morphine allergy death"
Michigan Court of Appeals, Dec. 8, 1975
from *The Citation,* Vol. 33, No. 4

Surgeon May Not Testify To Standard Of Care For Reading X-Rays

(The following medico-legal case study is reprinted here from the Sept. 1 edition of the AMA bulletin, The Citation, *at the suggestion of MSMS Legal Counsel A. Stewart Kerr, Detroit.)*

A trial court properly ruled that a surgeon was not qualified to testify to the standard of care for reading X-rays, a Michigan appellate court said.

A patient injured her ankle and was treated in a hospital emergency room. A surgeon, who was on duty in the emergency room, wrapped her ankle in an Ace bandage and told her to take aspirin for the pain. It was later determined that the ankle was fractured.

Claiming that the surgeon who treated her was negligent in failing to diagnose and treat the fracture, the patient and her husband brought an action against the surgeon and the hospital. The court dismissed the claim against the surgeon and ruled that another surgeon who was called as an expert witness for the patient could not testify because he lacked the qualifications of a radiologist. The court granted the plaintiffs' motion for a mistrial, so that the plaintiffs could appeal.

The appellate court said that the trial court should not have dismissed the suit. The patient had evidence other than the testimony of the expert witness, and she should have been permitted to present it.

In considering the trial court's ruling on the expert witness' testimony, the court said that the similar community rule applied. In Michigan, specialists, such as surgeons, are not held to the similar community standard but must meet the broader standard of the reasonable specialist practicing medicine in light of present day scientific knowledge. In rendering emergency room treatment, however, the defendant surgeon was not using any special skills or practicing surgery. Therefore, the surgeon was subject to the similar community rule.

Since the expert witness had never practiced in the community, and he stated that he was not entitled by training to read, quote or diagnose from X-rays, he was not qualified to testify to the standard of care required of hospital employees who examine X-rays. — *Callahan v. William Beaumont Hospital,* 240 N.W. 2d 781 (Mich. Ct. of App., Feb. 10, 1976)

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the five-week period ending Oct. 1, 1976

	1976 This 5-Week Period	1975 Same 5-Week Period	1976 Total To Above Date	1975 Total Same Date	Total Cases for 1975
Rubella	16	22	1,377	1,419	1,975
Cong. Rubella Syndrome	0	0	0	1	1
Measles	18	11	5,848	3,016	3,253
Whooping Cough	5	17	58	65	98
Diphtheria	0	0	0	1	1
Mumps	20	117	4,845	8,086	9,979
Scarlet Fever & Strep Sore Throat	1,246	1,197	17,889	17,112	23,777
Tetanus	0	0	1	0	0
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	278	281	1,949	2,157	2,877
Salmonellosis (other than S. typhi)	92	98	672	627	864
Typhoid Fever (S. typhi)	0	0	8	5	10
Shigellosis	39	97	428	572	745
Aseptic Meningitis	31	98	106	177	280
Encephalitis	12	33	63	80	168
Meningococcic Meningitis	2	6	51	64	76
H. Influenza Meningitis	4	14	96	99	142
Tuberculosis	143	91	1,042	878	1,220
Syphilis	93	148	786	1,235	1,614
Gonorrhea	3,641	3,502	25,654	23,548	32,472

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

RECENT CHANGES
federal register
highlights
Providing Drug Information to Physicians
Informational Bulletin #433-76
To
Subject
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

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category 1 programs

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

DATE: Nov. 16, Management of Advanced Cancer of the Breast
LOCATION: Wayne County Medical Society headquarters, 1010 Antietam, Detroit 48207
SPONSOR: WSU Department of Oncology
FOR: Oncologists
COST: $20
CONTACT: WSU-Division of CME**
APPROVED FOR: 2½ hours of Category I Credit

* * *

DATE: Nov. 17, Annual Thyroid Workshop
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit, 48207
SPONSOR: WSU Department of Internal Medicine
FOR: All interested physicians
COST: $20
CONTACT: WSU Division of CME**
APPROVED FOR: 6 hours of Category I Credit

* * *

DATE: Nov. 17, Lecture Series in Ophthalmology, "Vitrectomy — Status Report"
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Ophthalmologists
COST: No charge
CONTACT: Department of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Category I Credit

* * *

DATE: November 17-18, Second Annual Pulmonary Seminar for Family Physicians
LOCATION: Harper/Webber Auditorium, Detroit Medical Center
SPONSOR: WSU School of Medicine, Departments of Family Medicine, Internal Medicine-Pulmonary Division, Pediatrics, and Div. of Postgraduate and CME; Michigan Academy of Family Physicians; American Lung Association of SE Michigan
FOR: All interested physicians
COST: $60.00
CONTACT: Miss Gibson or Mrs. Murray, American Lung Association of SE Michigan (313) 961-1697
APPROVED FOR: 16 hours of Category I Credit

* * *

DATE: November 23, Continuing Pathology Conference
LOCATION: Towsley Center for Continuing Medical Education
SPONSOR: U-M Office of Intramural Education*
FOR: Pathologists
COST: $20
CONTACT: U-M Office of Intramural Education*
APPROVED FOR: Hour-for-hour Category I Credit

* * *

DATE: Nov. 26-29, Ophthalmology: Basic and Clinical Review
LOCATION: Dearborn Inn
SPONSOR: Kresge Eye Institute, WSU School of Medicine
FOR: Ophthalmologists
COST: $400
CONTACT: Arthur Sapere, Program Registrant, McGregor Memorial Conference Center, Wayne State University, Detroit 48202
APPROVED FOR: 40 hours of Category I Credit

* * *

DATE: Dec. 1, Cardiology for Family Physicians
LOCATION: Towsley Center for Continuing Medical Education, University of Michigan
SPONSOR: U-M Office of Intramural Education, Dept. of Postgraduate Medicine & Health Professions Education
CO-SPONSOR: Michigan Academy of Family Practice
FOR: All interested physicians
COST: $60
CONTACT: Office of Intramural Education, Dept. of PGM/HPE, Univ. of Michigan
APPROVED FOR: 8 hours of Category I Credit

* * *

DATE: Dec. 1-3, Introduction to Data Retrieval and Display
LOCATION: Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, 48105
SPONSOR: Commission on Professional and Hospital Activities
FOR: PAS member hospital teams
COST: $180
CONTACT: CPHA, 1968 Green Road, Ann Arbor 48105
APPROVED FOR: 9 hours of Category I Credit

* * *

DATE: Dec. 3-4, Symposium on Trauma
LOCATION: Harper Hospital, Detroit
Sponsor: Michigan Committee on Trauma, American College of Surgeons; and WSU Department of Surgery
FOR: All interested physicians
COST: $50
CONTACT: Joseph L Posch, MD, Harper Hospital (313) 962-0727
APPROVED FOR: 10 hours of Category I Credit

* * *

DATE: Dec. 15, Lecture Series in Ophthalmology, "Intraocular Lens"

LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Ophthalmologists
COST: No charge
CONTACT: Department of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Categeory I Credit

* * *

DATE: Jan. 4-Mar. 22, Radiologic Physics II
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
SPONSOR: WSU Department of Radiology
FOR: All interested physicians
COST: $66
CONTACT: WSU Division of CME**
APPROVED FOR: 2 hours per session, 20 course hours of Category I Credit

* * *

DATE: Jan. 5-March 23, Clinical Nuclear Medicine I
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
SPONSOR: WSU Department of Radiology
FOR: All interested physicians
COST: $66
CONTACT: WSU Division of CME**
APPROVED FOR: 2 hours per session, 20 course hours of Category I Credit

* * *

DATE: Jan. 10-Mar. 26, Pathophysiology of Hemostasis
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit, 48201
SPONSOR: WSU-Department of Pathology
FOR: All interested physicians
COST: $100
CONTACT: WSU Division of CME**
APPROVED FOR: 2 hours per session, 20 course hours of Category I Credit

* * *

DATE: January 12-March 16, Medical Therapy — An Update
LOCATION: Saint John Hospital, Detroit
SPONSOR: Saint John Hospital
FOR: All interested physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road, Detroit, 48236
APPROVED FOR: 20 hours of Category I Credit

* * *

DATE: Jan. 17-21, Topics in Emergency Medicine
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
SPONSOR: WSU Department of Surgery
FOR: All interested physicians
COST: $150
CONTACT: WSU Division of CME**
APPROVED FOR: 30 hours of Category I Credit

* * *

DATE: Jan. 18, Detroit Cancer Club Seminar, Carcinoma of the Lung
LOCATION: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207
SPONSOR: WSU School of Medicine, Department of Oncology
FOR: All interested physicians
COST: $20
CONTACT: WSU Division of CME** or Melvin L. Reed, MD, 4160 John R., Detroit, 48201
APPROVED FOR: 2½ hours of Category I Credit

* * *

DATE: Jan 19, Lecture Series in Ophthalmology, "Indications

The following have been accredited by MSMS Commission on Continuing Medical Education as of Sept. 1, 1976.

Organizations:

- Ann Arbor Psychiatric Association
- Michigan Academy of Family Physicians
- Michigan Academy of Plastic Surgery
- Michigan State Medical Society
- Michigan Chapter, American Academy of Pediatrics
- Michigan Dermatological Society
- Michigan Heart Association
- Michigan Lung Association, Lansing
- Univeristy of Michigan School of Public Health

Hospitals:

- Alma-Gratiot Community Hospitals, Alma
- William Beaumont Hospital, Royal Oak
- Beyer Memorial Hospital, Ypsilanti
- Blodgett Memorial Hospital, Grand Rapids
- Bon Secours Hospital, Grosse Pointe
- Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
- Butterworth Hospital, Grand Rapids
- Detroit-Macomb Hospital Association
- Grace Hospital, Detroit
- Henry Ford Hospital, Detroit
- Holy Cross Hospital, Detroit
- Hurley Medical Center, Flint
- Ingham Medical Center, Lansing
- Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
- McLaren General Hospital, Flint
- Mercy Hospital, Port Huron
- Mt. Carmel Mercy Hospital & Med. Center, Detroit
- Munson Medical Center, Traverse City
- Oakland Medical Center, Pontiac
- Oakwood Hospital, Dearborn
- Pontiac General Hospital, Pontiac
- Port Huron Hospital CME Committee
- Providence Hospital, Southfield
- Saginaw Cooperative Hospitals Inc., Saginaw
- Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
- St. John Hospital, Detroit
- St. Joseph Hospital, Flint
- St. Joseph Mercy Hospital, Pontiac
- St. Joseph Mercy Hospital, Ann Arbor
- St. Lawrence Hospital, Lansing
- St. Mary's Hospital, Grand Rapids
- Sinai Hospital of Detroit, Detroit
- Edward Sparrow Hospital, Lansing
- Traverse City State Hospital, Traverse City
- V. A. Hospital, Battle Creek
- Wayne County Psychiatric Hospital, Eloise
- Ypsilanti State Hospital, Ypsilanti

CATEGORY I/*Continued*

for and Complications of Keratoplasty"
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Ophthalmologists
COST: No charge
CONTACT: Department of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Category I Credit

* * *

DATE: Jan. 26, What's new in Obstetrics?
LOCATION: Saint John Hospital, Detroit
SPONSOR: Saint John Hospital
FOR: Obstetrics
COST: $50
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road, Detroit, 48236
APPROVED FOR: 7 hours of Category I Credit

* * *

DATE: Jan. 24-28, Family Practice Review
LOCATION: Towsley Center, Ann Arbor
SPONSOR: U of M Office of Intramural Education
CO-SPONSOR: Michigan Association of Family Physicians
FOR: Family physicians
COST: $250
CONTACT: U of M office of Intramural Education*
APPROVED FOR: 37½ hours of Category I Credit

* * *

DATE: Feb. 16, Lecture Series in Ophthalmology, "The CO_2 Laser in Ocular Surgery"
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Ophthalmologists
COST: No charge
CONTACT: Department of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Category I Credit

* * *

DATE: Feb. 21-25, Emergency Medicine
LOCATION: Towsley Center, Ann Arbor
SPONSOR: U of M Office of Intramural Education*
CO-SPONSOR: American College of Emergency Physicians, Michigan Chapter
FOR: Emergency physicians
COST: Approx. $250
CONTACT: U of M Office of In-

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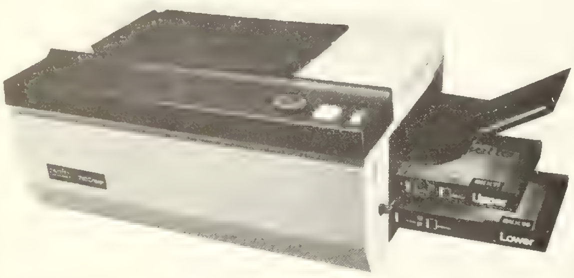
*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000



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APPROVED FOR: Approx. 36 hours of Category I Credit

* * *

DATE: March 30-31 — Annual Michigan Conference on Maternal and Perinatal Health
LOCATION: Kalamazoo Center Inn, Kalamazoo
SPONSOR: MSMS
FOR: All interested physicians
COST: None
CONTACT: Herbert Auer, MSMS headquarters
APPROVED FOR: Tentative 7 hours of Category I credit

* * *

DATE: March 15, Cancer of the Colon and Rectum
LOCATION: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207
SPONSOR: WSU Department of Oncology
FOR: All interested physicians
COST: $20
CONTACT: WSU Division of CME**
APPROVED FOR: 2½ hours of Category I Credit

* * *

Continuing Courses

DATE: Every Friday, through July, 1977, Neurology Conference
LOCATION: 4 Morse Auditorium, Harper Hospital
SPONSOR: Wayne State University Department of Neurolog
FOR: Internists, neurologists, neurosurgeons, pediatricians, family doctors
COST: None
CONTACT: Beverly Wolf, Department of Neurology, 3990 John R, Detroit, 48201
APPROVED FOR: 2 hours Category I Credit

* * *

DATE: Every Saturday, Weekly Conference
LOCATION: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey
SPONSOR: Burns Clinic/Little Traverse Hospital
FOR: All interested physicians
COST: None
CONTACT: Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770
APPROVED FOR: Hour-for-hour Category I Credit

* * *

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at 1-800-841-8000; or write to:
Navy Medical Programs
426 Clinton St.
Detroit, Michigan 48226

DATE: Begins September, 1976, Continuing Training in Family Therapy
LOCATION: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield
SPONSOR: Family Institute of Southeastern Michigan
CO-SPONSOR: Ackerman Institute
FOR: Psychotherapists
COST: Varies according to time put in
CONTACT: Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan
APPROVED FOR: Hours vary with time spent

* * *

DATE: Saturdays, Morbidity and Mortality Conference
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital Department of Surgery
FOR: Surgeons
COST: None
CONTACT: Office of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Category I Credit per session

* * *

DATE: Monthly, Cleft Palate Clinic
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Oral Surgeons, plastic surgeons, pediatricians
COST: None
CONTACT: Office of CME, Sinai Hospital of Detroit****
APPROVED FOR: 3 hours of Category I Credit

* * *

DATE: Monthly, Tissue Audit (Cancer)
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Surgeons, ob-gyns, pathology, radiology
COST: No charge
CONTACT: Office of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours per session Category I Credit

LIBRIUM®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
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■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Michigan producing more family physicians

The Michigan Academy of Family Physicians is generally pleased with the progress of Michigan programs in producing new family physicians.

"We are pleased with the general acceptance of the concept of family practitioners and the kinds of physicians our programs are producing. We are pleased to see family physician programs are moving ahead fairly rapidly," says Robert J. Toteff, MD, Saginaw.

"But we wish the monies the legislature could give us would be more," adds the chairman of the Family Practice Residency Fund Committee of the Michigan Academy of Family Physicians (MAFP).

The MAFP Fund's initial request was for $1.2 million for the supplemental funding of family practice residency programs in 1976-77. Following setbacks and temporary removal from the state budget altogether, the residency programs now are allocated $500,000 in state funds.

But this is better than being removed entirely from the budget and the MAFP Fund Committee accepted the reduced amount as the most reasonable way to go."

"If we can retain the funding item in the budget, the possibility exists for supplemental funding later in the year, should the economy and financial climate improve as expected. We felt that trying to reinsert a deleted budget item would be fraught with little chance of success," wrote Doctor Toteff in his recent annual committee report to the MAFP.

Statistics presented at that MAFP annual meeting in July in Traverse City show a total of 29 persons have completed family practice residency programs in Michigan to date. Twenty-eight of them are male, one female; 16 are white, two black and one Oriental.

Doctor Toteff points out that while 16 of the 29 are natives of other states, 20 of the 29 have established family practices in Michigan. Thus the state has retained some of the out-of-state FP trainees. Eighteen of the 29 have chosen to practice in communities of 50,000 persons or less, thus increasing the number of small-town family MDs.

A total of 128 physicians now are in family practice residencies in Michigan. "Only 15 residents of the total are foreign," comments Doctor Toteff. "This speaks to the number of American graduates seeking Family Practice training."

The AMA has estimated that 50% of physicians now in training throughout the US ought to go into primary medical care careers to meet peoples' needs, and 25% ought to be in family practice.

"We still have a long way to go to catch up with those figures," says Doctor Toteff.

"But we don't want programs established just for the sake of numbers," he says. "They have to be quality programs."

"We're glad to see the legislature enthusiastic about our programs. We just wish there were more money."

U-M to begin new residency in family practice

A comprehensive proposal for a new family practice residency program at the University of Michigan Medical School is now moving through channels of approval at the university.

"We are hoping for a search committee to be formed by the end of October," says George A. Dean, MD, Southfield, chairman of the U-M planning committee for the FP residency program. "We hope to have a professor of family practice on board by the end of January."

Doctor Dean was appointed a year ago by John A. Gronvall, MD, dean, U-M Medical School, as head of the planning committee.

Final approval now is expected from the University regents, who originally asked for the proposal to be studied and drawn up and have supported the concept all along.

"I think they realized that family practice is now a recognized specialty accepted by other physicians and that it is time the U-M developed a department and began to train family physicians", says Doctor Dean. "The need and desire have been shown by students, community and legislature."

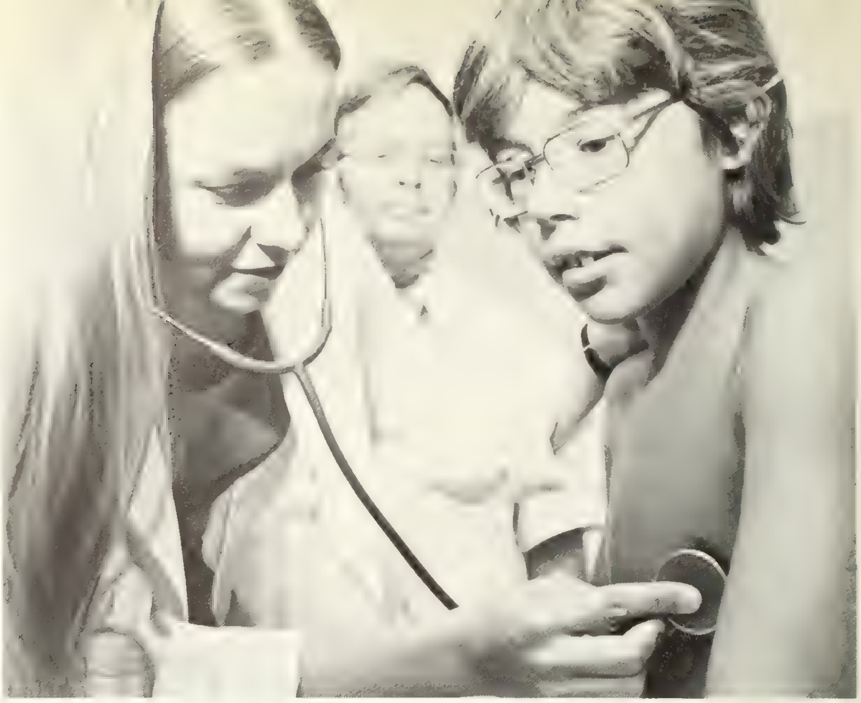
Actually, the legislature has appropriated $150,000 toward the proposed U-M family practice residency program the past two years, Doctor Dean points out.

"The dean and his staff have been sincere about this study right along," says Doctor Dean appreciatively. "I know Dean Gronvall is desirous of having a strong family practice department."

The planning committee recommended in its report that the new residency program be located at Wayne County General Hospital, where they found enthusiasm for the program.

The recommended target date for initiating the residency program is July 1, 1978.

Primary care preceptorships facing loss of funds



Donald C. McCorvie,MD, Williamston family physician, observes as MSU College of Human Medicine third year student Louise Mattson-Heron listens to heart sounds of a young patient. Ms. Mattson-Heron is serving a preceptorship with Doctor McCorvie.

Staff of the Michigan Cooperative Primary Care Preceptorship Program has begun a search for funds to replace a federal grant which has helped support the program during its first five years.

The federal seed money for the student training program runs out next spring at the end of the initial grant period. At that time the schools will lose $150,000-$200,000 each per year.

"We are very concerned for the funding aspect of this program," says Roy J. Gerard, MD, chairman, Department of Family Practice, Michigan State University. (Each of the three Michigan medical schools has a part in administrating the program.)

By the end of the 1976-77 academic year, nearly 1,800 Michigan medical students will have gained personal, on-the-job experience through the program, sharing and learning about the professional lives led by today's primary care practitioners.

The students range from first- to fourth-year levels in education. They share the doctors' work days by interviewing patients, taking histories, assisting in exams, learning about tests and gaining insight into decision making.

Currently there are 325 community physicians serving as volunteer preceptors. During the summer, 200 of them have students joining them. The remainder are teacher-practitioners during the fall-winter-spring academic terms.

The preceptorship program, sponsored by the medical schools, is the nation's largest office-based education program for medical students.

Physicians taking part in the program mostly are internists, pediatricians, family and general practitioners — those most likely to first encounter patients, common health problems.

Medical school personnel say one of the most impressive things about the program has been the "tremendous contribution of the physicians."

"Some of them give up a great deal of time and freedom to act as teachers," says Nancy Houston, MSU Information Services Health and Medicine Editor.

"But the students see what the doctors have to deal with, and the doctors see what the students are learning. Many physicians say they enjoy having a student in the office as another professional to talk things over with."

By the time the five-year program ends, it is estimated that physicians will have contributed $4¼ million worth of teaching effort to the medical training of the 1,800 students who have taken advantage of the program. That is based on $50 for each of a minimum of 50 extra student hours in each physician's schedule.

In a recent evaluation, nearly all of the physicians who have participated (99%) said they enjoyed instructing the medical students. Slightly less (94%) said they would take a student again. More than 90% said they would recommend hiring the student for their hospital staff.

It is difficult yet to assess whether the students who have taken part are selecting primary care for their medical practice after graduation and a Michigan locale for that practice, two major goals of the program.

But preliminary information does show one-third to one-half of the students who took part in earlier years are planning to join the ranks of primary health care practitioners.

It is with these good results and goals in mind that the medical schools are seeking the funds to carry on with the program. *Michigan Medicine* and *Medigram* will keep you informed of their progress.

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"Hospital Construction Savings With CM" a brief informative presentation may be scheduled by you individually or by hospital management committees without obligation. Please call or write: Tom Brady, Barton-Malow Construction Management Services, P.O. Box 5200, Detroit, Michigan 48235, (313) 548-2000.

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Letters

"What would you do if member of admissions committee?"

Doctor Dale K. Morgan's Commentary (*Michigan Medicine,* August, 1976) on "Put rural kids in medical school; we'll get them back," highlights a number of problems in medical education. However, none of these issues are as black and white, nor as simplistic in solution, as Doctor Morgan implies.

Essentially the issues Doctor Morgan raises relate to (1) retention of Michigan medical school graduates in this state and a physician shortage, and (2) selection of applicants to medical school. Permit me to respond to each of these.

While it is true that somewhere near half of the graduates from Michigan medical schools leave the state for their first year of graduate training (this varies from year to year, school to school), AMA and MSMS figures indicate that over 54% of U.S. medical school graduates practicing in Michigan today were trained at Michigan medical schools.

Also, a soon-to-be-published study by the Michigan Office of Health and Medical Affairs will show that if present trends continue, within a few years Michigan medical and osteopathic schools will be graduating about 700 new physicians a year; the in and out migration for graduate training and for established physicians in practice averages out over time about equal to the number of medical school graduates. This trend is expected to continue. Michigan loses about 300 physicians a year due to death, moving and retirement, and as this continues we will have a net gain of approximately 400 physicians a year.

We must make Michigan an attractive place in which to practice. A major effort along these lines is being undertaken by the Statewide House Officers Training System (SHOTS) program, of which MSMS is an active member. Repeated studies and experiences indicate that of all the factors which determine where a physician locates for practice, a continuing major influence is the location of his/her graduate training. If a physician trains in an area, chances range up to three to one that he/she will locate for practice in that geographical area. A logical extension of this is to improve the quality, numbers, and location throughout Michigan of attractive graduate training programs.

SHOTS is attempting to develop a central resource to aid graduate training programs in Michigan so that we can better meet the physician manpower needs of the state, numerically, geographically and qualitatively.

Is there a physician shortage in Michigan? This is argued and debated in numerous circles, and the answers are not easy to come by. Number of physicians is one thing; geographic distribution is another, as is specialty location. A study in the MSMS August, 1974, *Research Bulletin,* states in conclusion, "that when examined on an area (17 health center areas were used) basis rather than a county basis, the maldistribution problem of physicians and hospital beds is not as drastic as it usually appears to be on paper." It is further pointed out that only a few areas have acute problems, that generalists appear to be fairly well distributed throughout Michigan, but there are areas short in both number of physicians and in specialists.

"The real maldistribution lies in the spread of specialists in Michigan. The current trend toward primary care physicians will help alleviate the problem of having enough physicians for general care, but will further exacerbate the maldistribution of specialists," the study states.

How to Select Applicants?

Second, the issue of selecting applicants for admission to medical school is an enormous one, both from the standpoint of pure numbers and quality. For the 1975-1976 entering classes at the University of Michigan Medical School, Wayne State University School of Medicine, and Michigan State University College of Human Medicine, there were 10,533 applicants for 562 first year positions, a massive screening job to be sure. Nationally there were about 45,000 applicants for 15,000 first year positions.

"Send me a set of maternal health desk reference cards."

Since graduating from MSU College of Human Medicine in 1973, I have been in the residency program of the Department of Family Practice at the Medical University of South Carolina in Charleston. I have kept up with the Journal of the MSMS which comes to the medical school library here.

I came across one of the Maternal Health Desk Reference Cards and found it very interesting. Would you send me a set of them?

Larry E. Davis, MD
Charleston, SC

(Editor's Note: Sets of the Desk Reference Cards, on such topics as Fetal-Maternal Electronic Monitoring, Rubella Diagnosis, Immunization during Pregnancy, are available by writing the Special Services Department, MSMS, Box 950, East Lansing, 48823.)

Admissions committees are composed of faculty members, students, and community physicians. Biographical information, college academic record, Medical College Admission Test (MCAT) scores, the applicant's personal comments, and faculty admissions committee evaluations receive major attention in the screening process. Final selection is based on the above factors, plus a personal interview.

What would you do if you were a member of a medical school admissions committee with three or more applicants for each position in your class? Two out of three of the applicants are fully qualified. Costs continue to rise. Pressures increase from society to meet a shortage of primary care physicians, and to train more doctors from minority groups. You might be tempted to push the pile of applications aside. But then, this isn't practical; so while we continue to admit on the basis of a brief interview, some unrevealing letters, college grades, and a handful of test scores we must search for better ways to select medical students.

The Association of American Medical Colleges (AAMC) is in the final stages of revising the old MCAT into something hopefully more realistic and comprehensive; the new tests will be looking for two things: a relatively culture-free measure of an applicant's communication and analytical skills, and some measure of the applicant's commitment to medicine and human needs.

Programs in New Mexico, Florida and other medical schools are in the forefront of pioneering innovative ways of working with minorities, women, and students from rural backgrounds; the MSU Upper Peninsula medical education program is designed to implement a community-based, decentralized medical education program which is responsive to the needs and characteristics of the Upper Peninsula and rural areas in general. Studies and programs from some medical schools aimed at determining whether students from rural or urban backgrounds tend to practice in these areas are fairly recent and inconclusive.

Answers Hard to Find

Where does the answer lie? In an editorial in the *Journal of Medical Education,* December 1972, Robert A. Green, M.D., Associate Dean, University of Michigan Medical School, indicated that "a number of more radical solutions (to the admissions dilemma) have also been suggested with varying degrees of seriousness which have generally met with little enthusiasm." These include:

1. A quota system for each school by ability, age, sex, race, economic standing, ethnic background, geographical place of

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residence, and other factors to fill places.

2. Open admissions where entrance would be granted to any student meeting specified academic standards, with the true selection being made prior to entrance to the clinical years where hospital facilities and faculty would limit the number who could be properly trained.
3. A lottery where all who meet minimum standards would be selected at random for each school on the total number of positions available, and also on the desired resident-nonresident ratio.
4. A matching plan similar to that used in the National Intern and Resident Matching Program.

The above discussion does not claim to offer *the* solution or *the* answer to the questions of how to select medical students or how to train and retain more and better physicians in Michigan. It is hoped, however, that it does shed some light on a series of complex issues.

The Michigan Medical Schools Council of Deans, through a number of advisory and study committees, continually addresses these issues; the SHOTS program, the MSMS, and countless other groups and organizations are vitally concerned. Issues such as those raised by Doctor Morgan need to be brought before the profession and public, and they must be addressed and responded to by responsible and concerned groups.

Ralph M. Lewis, MDH
Executive Director
Michigan Medical Schools
Council of Deans
Executive Secretary
Statewide House Officers
Training System

" . . . thank you very much . . . "

Just a brief note to thank you very much for sending me a copy of the Journal with the crisis intervention article. As always, you did a masterful editing job!

Jose J. Llinas, MD
Executive Director
North Central Florida
Community Mental Health Center

"Could you send some LMD-74 forms?"

I appreciated the question and answer section on CME in the recent *Medigram*, but I don't seem to have the LMD-74 form you refer to. Could you send some to me?

Robert Bulten, MD
Brookville Youth Clinic
Grand Rapids

(Editor's note: Copies of the state's CME reporting form are available from Mrs. Marcelyn Ireland of the MSMS staff, and from the Medical Practice Board, 1033 S. Washington, Lansing, 48926.)

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PRACTICE MANAGEMENT

Net worth, not earnings determines future security

By R. Timothy Hogan
Ann Arbor

It has been said that physicians are poor business persons. Many doctors spend their money as if they are trying to prove this statement true. Their income may have increased over the years, but it never seems to keep up with spending.

Try to avoid this spend-first, earn-later syndrome.

Do a complete physical examination of your financial health. What is your accumulated net worth? (This is the difference between what you own and what you owe and is a measure of your financial success.)

Are you able to determine what you earn and what you spend and the resultant net gain or loss on a regular basis throughout the year?

An income and expense statement is a prerequisite in financial planning. It will enable you to visualize your financial situation and help you to control your finances and chart your progress. Monthly and yearly to-date figures should be listed. Many reports of this type show only professional income and expense. You should also determine any other income and summarize personal spending payments including household expenditures, savings, investment plans, loan payments, taxes, insurance, education costs and other regular payments such as alimony or contributions.

This will necessitate the cooperation and involvement of your spouse. Regardless whether husband or wife handles normal family finances, i.e. payment of household bills, the other spouse should have knowledge of average monthly expenditures and net income.

Once you determine what you earn and what you spend, you will be in a position to discuss what you wish to accomplish financially, establish priorities and set goals to be attained. Regardless of your income, you should determine what you can afford and how much you have available to spend before making a commitment.

Be realistic in setting goals and developing a plan for financial security. This should apply to your own individual situation and not necessarily be measured against what someone else has apparently achieved.

Undoubtedly you can make the assumption that there will be future inflation, with rising costs professionally and personally, and also increased taxation.

Some common goals related to financial security that can be achieved through financial planning are reviewed briefly in the following paragraphs.

INSURANCE: The basic concept to be kept in mind is that insurance provides protection against catastrophic loss, hazards or death.

The earning potential of your spouse and family should also be considered when reviewing insurance needs. You should determine what you wish to protect against and then consult a reputable insurance agent who will be available to provide service on a continuing basis.

Coverage through your professional corporation should be coordinated where applicable. Savings in premiums with adequate coverage may be obtained through your medical society or specialty groups.

ESTATE PLANNING: This is an important and continuing part of financial planning and includes the liquidation of your practice and retirement plans in addition to conservation of other assets. Estate and inheritance taxes may be minimized through the use of trusts, gifts and ownership of assets. Both you and your spouse should have up-to-date, properly-written wills. An attorney familiar with estate planning and taxes should prepare these documents. Wills should be reviewed at least every five years or during the coming year with proposed estate tax revisions.

HOUSING: Your home should not be considered as an investment except in personal comfort and satisfaction. It can be an inflation hedge as you build equity, but it may also cost you more to move into another house. Many times an expensive home is sold at a loss due to a forced sale in the case of death or relocation. Mortgage costs and interest rates vary with lending institutions and it is worthwhile to obtain more than one quotation when obtaining a mortgage.

EDUCATION: As many of you have discovered, the costs of educating your children continue to increase. State schools located where you reside have considerably lower fees than private institutions. While your children are young, you should begin to set aside education funds in savings certificates, mutual funds or trusts to build a reserve for future education expenditures. This can be a tremendous drain on your current finances if you have not done some preliminary planning.

CASH RESERVE AND INVESTMENTS: You should build a cash reserve to meet contingencies or enable you to take advantage of special investment situations. This might include a tax and insurance account to

---

Mr. Hogan is a consultant with Professional Management, Black and Skaggs Associates, Ann Arbor.

cover payment of personal and professional insurance premiums and income and real estate taxes.

Stats available on anesthetics

Statistics on the number of anesthetics administered per year per size of hospital and the percentage and number of cases anesthetized by MDs and other hospital personnel are available from the Michigan Society of Anesthesiologists, Inc. Write to Donald W. Hesselschwerdt, MD, District Director, Michigan Society of Anesthesiologists, Inc., 120 W. Saginaw St., Lansing, MI 48823.

You should institute an investment program of fixed income funds and equities that provide an inflation hedge, of future value with possible tax shelters and of satisfaction and comfort to you personally. You should also understand the difference between investing and speculating.

When investing you should determine the amount of money available for investment, the time period involved, and the rate of return or projected growth. Reinvestment of dividends and compounding of interest can add to the value of your investment.

RETIREMENT PLANNING: This is an integral part and end result of financial planning. Will you be able to retire financially if you so desire? Pension, Profit Sharing, Keogh and T.I.A.A. plans may provide tax shelter with forced savings and should be taken advantage of in some form by most physicians.

You should review your own particular goals periodically as your personal situation changes and make revisions in your planning where indicated.

Remember, it is not necessarily what you earn, but rather the net worth you accumulate and retain that will provide future financial security.

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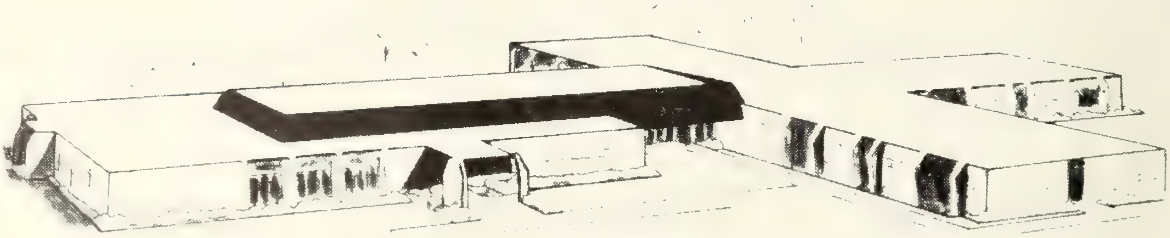

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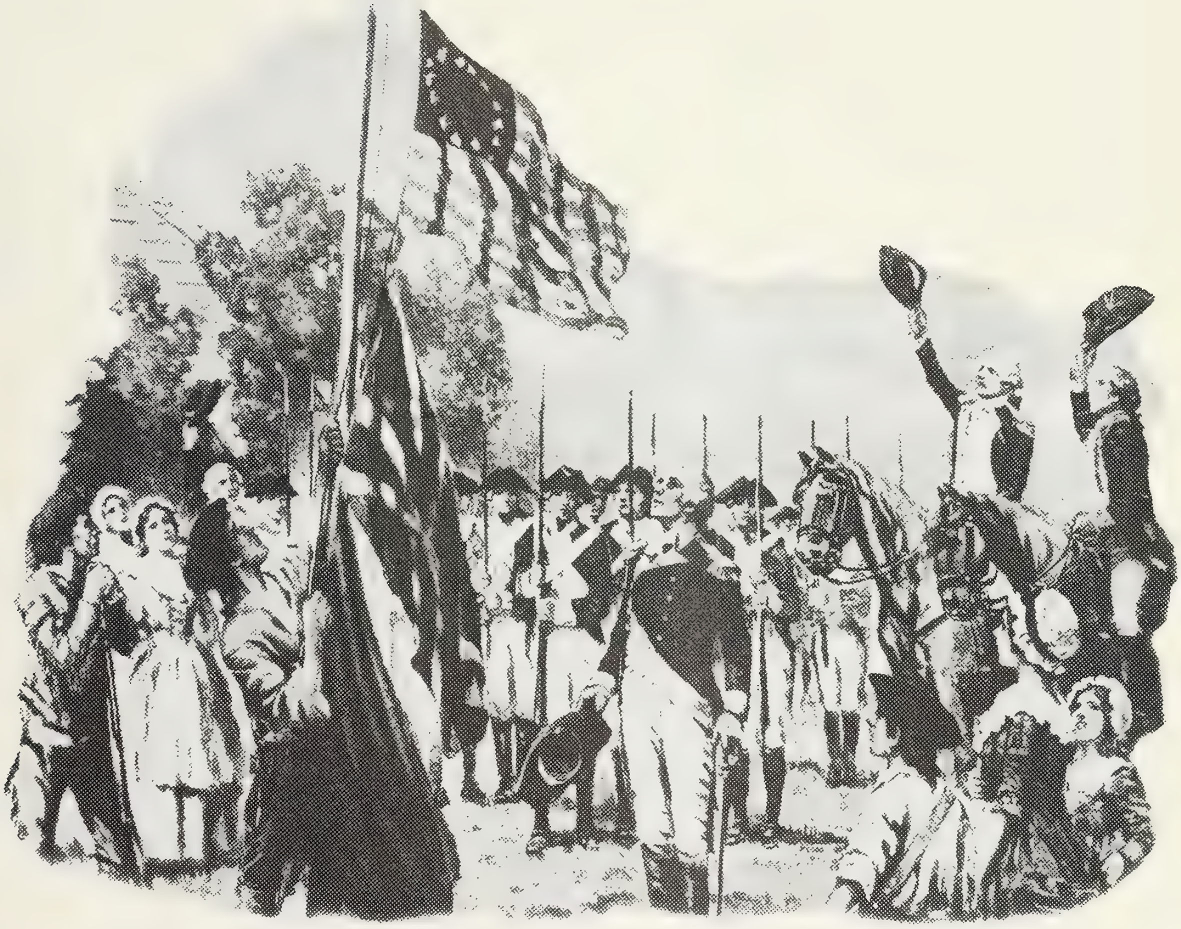

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in memoriam

Robin Adair, MD
West Bloomfield

Robin Adair, MD, former chief of staff at St. Joseph Mercy Hospital, Pontiac, died Sept. 25 at the age of 60. Doctor Adair also was affiliated with William Beaumont Hospital, Royal Oak. He was a graduate of Wayne State University School of Medicine and was affiliated with the Michigan Society of Obstetricians and Gynecologists.

Malcolm D. Campbell, MD
Plymouth

The head of the outpatient emergency service at Delray General Hospital, Detroit, for 30 years, Malcolm D. Campbell, MD, died Sept. 26 at the age of 90. Doctor Campbell had served with the Canadian Army Medical Corps during World War I, and also had served in the Ford Motor Company Hospital with Henry Ford I. He also had worked with the state tuberculosis clinics. He was a graduate of the University of Western Ontario medical school and was affiliated with the Trudeau Society and American Academy of Chest Physicians.

John A. Engels, MD
Richmond

Long-time Richmond area family physician John Adam Engels, MD, died Sept. 8 at the age of 71. Doctor Engels was past president of the Macomb County Medical Society and former chief of staff at St. Joseph Hospital, Mt. Clemens. He was a graduate of the University of Michigan Medical School. He was named Richmond's "Citizen of the Year" in 1960.

Dwight Dutcher, MD
Grosse Pointe

Well-known Detroit-area family physician Dwight Dutcher, MD, died Sept. 14 at the age of 54. Doctor Dutcher was a former member of the Wayne County Medical Society Council, past president of the WCMS General Practice Section, and a former director of the Michigan Academy of Family Physicians. Doctor Dutcher was a member of the board of directors and assistant director of the family practice residency program at Bon Secours Hospital. He also had served as chief of staff at Bon Secours.

William G. Gamble, Jr., MD
Bay City

William G. Gamble, Jr., MD, for 37 years chief pathologist at Mercy and General hospitals in Bay City, died Sept. 11 at the age of 79. Doctor Gamble was a graduate of the Medical College of South Carolina. He was past president of the Bay County Medical Society and editor of its Bulletin. He had received the 50-year award from the Michigan State Medical Society. Doctor Gamble was active in civic projects; Crippled Children, TB and blood collection programs, and was a former member of the state TB commission. He was a fellow emeritus of the American College of Surgeons and a member of several other specialty associations.

William Thomas Kruse, MD
Grand Rapids

A Grand Rapids dermatologist for 10 years, William Thomas Kruse, MD, died Sept. 22 at the age of 55. He was a graduate of the University of Michigan Medical School and a member of the American Academy of Dermatology. He had been retired following a stroke 15 years ago.

Juan E. Olivera, MD
Port Huron

Port Huron orthopedic surgeon Juan E. Olivera, MD, died Aug. 23 in a motorcycle accident. He was 44. Doctor Olivera was a native of Salamanca, Spain, and had practiced in Port Huron nearly 10 years. Previously, he had charge of orthopedic programs at Ernest Conseil Hospital, Tunis, Tunisia, under appointment with CARE-MEDICO. He was a fellow of the American Academy of Orthopaedic Surgeons.

Fernley Stoneman, MD
Grand Rapids

Grandville Medical Examiner Fernley Stoneman, MD, died Sept. 24 at the age of 56. He was a family physician in that city for 25 years. Doctor Stoneman also was affiliated with St. Mary's Hospital and Blodgett Memorial Medical Center in Grand Rapids. Doctor Stoneman was a graduate of the University of Michigan Medical School and was a member of the American Academy of Family Physicians. He had been an active member of the Grandville school board and had served as the community's team physician.

Darwin E. Wagoner, MD
Oscoda

Oscoda family physician for 41 years, Darwin E. Wagoner, MD, died Sept. 1 at the age of 76. He was past president of the Alpena-Alcona-Presque Isle Society and was a member of the American Academy of Family Physicians and the Air Medical Association. He had been affiliated with Alpena General and Tawas St. Joseph's hospitals and was active in community organizations. He was a former mathematics teacher and received his MD degree from Wayne State University School of Medicine.

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Port Huron, Michigan: Board eligible or certified pediatrician to join a well established growing 2 man practice. Modern office facility. Active pediatric service including special care and newborn nurseries in a 280 bed general hospital serving the surrounding area of Eastern Michigan. Located on Lake Huron, 60 miles from University related Children's Hospital. Opportunity for participation in ownership within a year. Outstanding, progressive family community with excellent water and land recreation. Good public schools, Kindergarten-12th grade. Also a 2 year community college. Contact: William D. Cleland, M.D., or Anthony C. Gholz, M.D., 1209 Tenth Street, Port Huron, Michigan 48060 (313) 985-7146.

NEEDED: Internists for the Traverse City, Oak Park, and Lansing offices of the Disability Determination Program under Social Security. Salary currently in high $30,000's plus 22% fringe benefits, including life, accident, longterm disability, and hospital insurance. Deferred compensation. Pension benefit after 10 years. No malpractice insurance required. 40 hour work week. No weekends or nights. 50 hours continuing medical education benefit. Job involves review of medical records, training and teaching, as well as some public relations. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Program, Box 30011, Lansing, Michigan 48909, OR call collect: David P. Gage, M.D., Chief Medical Consultant, (517) 373-7789.

PHYSICIAN WANTED: Vacancy for physician interested in mental retardation. This is a state institution caring for 1500 mentally retarded. Includes general hospital with ancillary services. Fringe benefits include medical and life insurance, sick leave, paid vacations, retirement, long term disability, etc. Michigan medical license required. Annual salary from $24,534 to $34,076 based on qualifications. Equal opportunity employer. Contact: Isak O. Berker, M.D., Medical Director, Oakdale Center for Developmental Disabilities, Lapeer, Michigan 48446.

NEEDED: Family Practice opportunity in rich farming community, West Central Iowa. Beautiful, progressive city with new hospital, 5 minutes to 100 bed hospital. Friendly community, good production contract well established 6 man group, short time to full partnership. Call: Ed Murphy, Carroll Medical Center, 502 N. Court, Carroll, Iowa 51401 (712) 792-1500.

WANTED: Ophthalmologist, board eligible or certified to help me in my busy practice. Winding down on surgery. New office adjoining mine. Beautiful Northern Michigan year round resort area. Open to any reasonable terms. If interested, contact M. D. Bentley, M.D., Office (616) 775-9353.

GASTROENTEROLOGIST-INTERNIST: 33, Foreign graduate, Board eligible for Internal Medicine, University trained, experienced in all endoscopic procedures seeks solo, partnership, multispecialty group or hospital based practice. Available July-August 1977. Reply Box 12, 120 W. Saginaw St., East Lansing, Michigan 48823.

FOR SALE: Hamilton examining table, lightwood. Bench type examining table with two drawers, instrument cabinet with matching instrument stand. Medicine cabinet metal. Mayo tray stand. Surgical examining light stainless steel trays, dishes and basins. Miscellaneous supplies, (Drapes, Gloves, Urine dip sticks, etc.). IBM Executive Typewriter. Norelco dictating equipment with pocket unit. Adding machine. Secretarial desk, swivel chair, waiting room furniture. Contact: B. Farvar, M.D., Olin Clinic, MSU, East Lansing, Mi 48824 or call (517) 355-4510 office hours, 351-8763 evenings.

POTPOURRI

By Herbert Auer, Executive Editor

"Capitalism — our free enterprise system — has produced a level of family income in this country so high that the federally established poverty level in the United States is higher than the average family income in the so-called second most powerful nation of the world — the U.S.S.R. Yet, this is the system that some people want to replace . . . because it hasn't performed well enough to suit them." — Herbert S. Richey, chairman of the Board of Directors, Chamber of Commerce of the United States.

* * *

Did you know that $400 million — yes, million — is wasted every year on devices said to cure arthritis. One of the most authentic publications for patients is "How to Cope with Arthritis," HEW Consumer Information Center, Dept. 42, Pueblo, Colorado, 81099. Sixty cents for the booklet will help people save their dollars.

* * *

Educators today are more interested in social behavior and social promotion than in achievement, says George Weber, director of the Council for Basic Education, Washington, D.C. He adds: "The blunt truth is that most of our schools are failing to meet the needs of a large portion of our young people.

* * *

A recent survey by the National Assessment of Educational Progress, Denver, disclosed that 11 per cent of the nation's 17-year-olds are functionally incompetent. They cannot read a newspaper, fill in a job application, or even read labels on medicine bottles.

* * *

First year enrollment in the fall of 1976 showed 24 percent increase in the 116 USA medical schools. There were 15,349 first-year students in the total of 57,236 — about 10 percent more than 1975.

* * *

Two professors at Stanford found in their research that the most common grammatical errors are (1) dangling modifiers, (2) overuse of the passive voice, and (3) failure to make the subject and verb agree. This would be good information to circle for the secretary.

* * *

The National Center for Health Statistics reports (1) home and family life is changing because one child of every six now lives in a single-parent home; (2) the number of families headed by women increased by 54% between 1960 and 1973; and (3) 51% of those families live in poverty.

* * *

The Code Authority of the National Association of Broadcasters, 477 Madison Avenue, NYC 10022, will welcome suggestions for a possible new policy relative to the advertising of contraceptive products over stations and networks.

* * *

Occasionally some new organizations using only letters catches my attention. There are ads running over one of the Detroit radio stations about the "TI Movement." I have now found out that the idea is a spoof. TI stands for Total Ignorance.

* * *

The third annual MSU College of Human Medicine alumni weekend heard Hilliard Jason, MD, formerly of MSU and now with the Association of American Medical Colleges staff, observe that most American medical schools fail to foster and nurture the type of graduate who will continue to learn after he becomes a doctor. A better groundwork must be laid in school for CME, he said.

* * *

Television is the only one of four community institutions (television, schools, government, newspapers) to rise in regard since 1959. When people were asked in 1959 which of the four was doing a good job, television rated last. Television moved to first position in 1967 and now shows a marked increase over a 1972 rating. This is one of the findings of the ongoing public attitude study by the Roper Organization.

* * *

Only 31 percent of 17-year-old students interviewed in a survey by the National Assessment of Educational Progress knew the name of their congressman or congresswoman. Would doctors score 100 percent?

* * *

Jim Fitzgerald, a new columnist with the Detroit Free Press, says, "I write to entertain, provoke and perhaps sway. I like to give people hell when they have it coming. I think it's fine if something I write makes someone cry — or jump up and down screaming."

* * *

An active and vital free market system would be far more effective, efficient and innovative than any government bureaucracy," wrote Senator Phil Hart in his recent *Washington Memo*. He contends the nation also must be sure that "antitrust laws are enforced and up to date".

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enables you to convert presently owned fixed assets into working capital.

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generally, lease payments are fully tax deductible. By moving capital investments into the fixed monthly expense column on the books, your company's tax load may be reduced. Leasing can also reduce administrative costs by eliminating the necessity to maintain depreciation and interest schedules. Simplified cost accounting, cost distribution procedures and more precise budget control, also usually result through leasing. One monthly invoice can cover all items leased.

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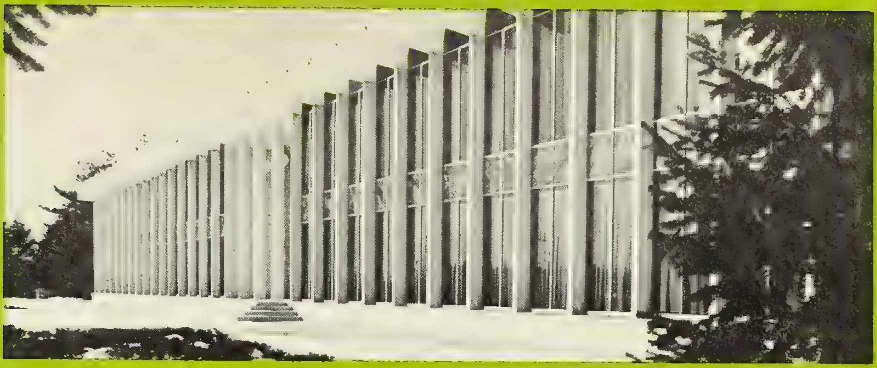


MICHIGAN MEDICINE

OFFICIAL JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY • VOLUME 75, NO. 12 DECEMBER 1976

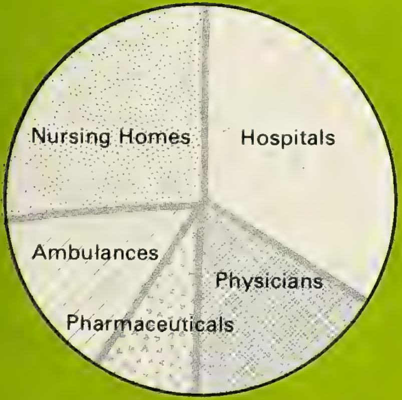
How the Privacy Act *affects the Social Security Disability Determination Program, as one example of the law's wide reach, is described on page 669.*

New federal tax law revisions *and how they affect the physician's investments and properties are described on pages 682 and 687.*

Are you familiar *with all the services of the Michigan Department of Public Health? Check the first in a series of articles on the MDPH beginning on page 675.*

The Michigan Blood Council *needs the cooperation of physicians all over the state in order to be an effective health care organization. Read about it on page 672.*

Medicaid fact and fancy *is the subject of a special article written just for* **Michigan Medicine** *and appearing on pages 665-668. Points to pass on to patients and others who should know about Medicaid are emphasized.*



The Medicaid reimbursement pie — doctors' share is 15%.

[illegible]
U.S. [illegible]
[illegible]

Both often

Predominant
psychoneurotic
anxiety
Associated
depressive
symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

respond to one

According to her major
mptoms, she is a psychoneu-
tic patient with severe
xiety. But according to the
scription she gives of her
lings, part of the problem
ay sound like depression.
is is because her problem,
hough primarily one of ex-
ssive anxiety, is often accom-
nied by depressive symptom-
logy. Valium (diazepam)
n provide relief for both—as
e excessive anxiety is re-
ved, the depressive symp-
ns associated with it are also
en relieved.

There are other advan-
ges in using Valium for the
anagement of psychoneu-
tic anxiety with secondary
pressive symptoms: the
ychotherapeutic effect of
lium is pronounced and
pid. This means that im-
ovement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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in psychoneurotic
anxiety states
with associated
depressive symptoms

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refully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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contents

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue . . .

Details of the new proposals to hold down costs in the Medicaid program, particularly those involving Michigan physicians, will be published in the January issue of **Michigan Medicine.** ***As*** **Medicine** ***already has informed you, the recommendations include elimination of the 11% discount of physician reimbursements, but imposition of a new 4% discount on payments to all providers, except hospitals.***

In addition, next month's journal will present the recent Blue Cross/Blue Shield study on length-of-stay depending on the day of admission to the hospital.

Watch for these important articles.

Michigan Medicine, Volume 75, Number 12, December 1976

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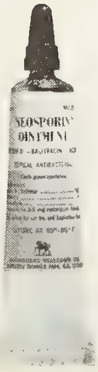
Complete literature available on request from Professional Services Dept. PML.



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Medicaid helping change the ballgame

Robert M. Leitch, MD
MSMS President

Medicaid problems continue to beset physicians as Michigan's model Medicaid program struggles with cost containment measures. Aim of the efforts is to somehow reconcile the difference between a program estimated to cost $860 million against a legislative appropriation of $811 million.

Why does Medicaid, like any governmentally provided service, continue to cost more than planners figure? Bureaucrats have apparently not yet learned that anytime a service is provided to the public at no cost or at a low cost through subsidies, demand for and utilization of that service is going to increase geometrically as the number of recipients grows. Add to this the continuing problems of inflation and the payout soars.

And though physicians receive only 15% of the Michigan payout for Medicaid services, they become the easiest targets of any cost containment measures. Hospitals, nursing homes, ambulance services, etc. account for the bulk of the payout, but it is more difficult for Medicaid officials to apply cuts against amorphous, non-human "institutions."

We have been living for some time now with the 11% cut in payments implemented by Social Services early this year. As this commentary was being written the debate was continuing on whether to restore the cut or continue it. One idea advanced was to restore the 11% to physicians and then implement a four percent cutback on *all* providers except hospitals, which must bear other cost containment measures.

No matter how you look at it, physicians are ultimately being asked to subsidize a government program which they are already paying for as tax-paying citizens.

Maybe the idea is far out or unusual . . . perhaps impossible, but it seems to me that the Michigan legislature might consider offering Michigan physicians caring for Medicaid patients a credit on their income taxes to offset the inequities created by the reimbursement system.

Such a tax credit would offer some consolation to those physicians who can actually document dollar losses in seeing these patients.

All of us who were in practice "PM" (Pre-Medicaid) can recall treating countless patients at no charge because we knew they had no means. Few of us today would refuse to treat a patient who truly needed help regardless of ability to pay. But it is increasingly apparent to all of us that the ball game is changing drastically as our costs continue to rise and the payment mechanisms from third parties and government continue to become more complex and restrictive.

(Please read the article beginning on page 665 for more Medicaid facts and figures.)

When **impotence** due to androgenic deficiency is driving them apart

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Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy,* Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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MSMS REPORT

How you benefit as an MSMS member

– by the representation of your viewpoints through MSMS liaison activities with Michigan organizations.

When a Michigan physician joins MSMS, his/her voice is joined with most other Michigan physicians' in a continuing dialogue with health care organizations, agencies, state and private health care groups.

MSMS leaders and staff sit on advisory boards, present testimony, assist in policy decisions, monitor activities, and serve as directors of a wide variety of groups affecting the delivery of health care to Michigan citizens.

Among the key liaisons maintained by MSMS are those with the Michigan Medical Practice Board; the Bureau of Medical Assistance (Medicaid) of the Department of Social Services; Blue Cross/Blue Shield of Michigan; the Michigan departments of health, of mental health and of education; and the medical schools.

MSMS members recently have been appointed to liaison activities with the new Michigan Association of Health Systems Agencies and the Statewide Health Coordinating Council, and meet periodically with representatives of the Office of Health and Medical Affairs.

MSMS members and staff carry on dialogue and meet regularly with other health professionals — nurses, osteopathic physicians, hospital administrators, pharmacists, physicians' assistants.

Selected consumer groups, medical students, adult educators, child sudy groups and health educators are included in MSMS liaison activities.

Other important contacts are made with foreign medical graduates, for which there is a separate MSMS committee. The news media around the state continually are contacted, informed, and brought up-to-date about physicians' concerns and activities.

Component medical societies are visited extensively by MSMS leaders and staff, led by MSMS President Robert M. Leitch, MD, Battle Creek, in a concentrated effort to inform and unite all MSMS members.

The charge to the MSMS liaison activities with governmental agencies, is "to develop and maintain liaison with state governmental agencies which deal with medical issues, in order to achieve MSMS objectives, and to monitor trends and portents."

That's a good example of the kind of informed, contributing interaction that MSMS liaison efforts provide for the benefit of all MSMS members.

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Warren F. Tryloff
Director

New MSMS office serves other medical groups

MSMS now offers administrative management aid to specialty societies and other organizations through the new MSMS Office of Special Services.

"We provide any and all executive services the contractors wish," says Helen Schulte, MSMS staff director of the Office of Special Services.

To date, organizations contracting for administrative services include the Michigan Psychiatric Society; Michigan Society of Anesthesiologists; State of Michigan Branch, American Association of Medical Assistants; Michigan State Medical Society Auxiliary, and, most recently, the Michigan Association of Medical Educators.

The MSMS Special Services Office keeps membership records for those organizations, performs accounting duties, covers board meetings, coordinates educational meetings and produces newsletters.

"Our main function is service — we're jacks of all trades," says Ms. Schulte.

The special services office has been functioning approximately one year. It offers advantages to smaller organizations unable to afford full-time staff, provides a central office location and services for organizations with common interests and ties, makes for improved internal and external communications, and provides continuity of programs and activities, which is a problem for most organizations with changing leadership. MSMS can apply its expertise and tested management techniques to other organization's programs.

Specialty societies under contract for MSMS services also benefit from direct MSMS activities in media relations, lobbying and all on-going MSMS programs.

Services are offered at nominal cost, and, in all cases, contracts are signed, tailored to the contractor's needs.

The management help seems to work well for the MSMS affiliates. Recently, Kenneth E. Pitts, MD, past president, Michigan Psychiatric Society, reported on a visit to American Psychiatric Association headquarters.

"They were extremely high in their praise of our administrative work," he says. "They said they wished office management of state psychiatric societies was handled as well as that in Michigan."

Ms. Schulte, left, and her assistant, Rene Morris.

The MSMS Council has two new members. They are, from left, William S. Jones, MD, Menominee, and Charles L. Oppy, MD, Roscommon. Doctor Jones and Doctor Oppy now work with MSMS Council Chairman Ernest P. Griffin, Jr., MD, right. They succeed Donald T. Anderson, MD, Kingsford, and Robert C. Prophater, MD, Bay City, respectively, who resigned from The Council earlier this year.

The one the patient takes is never tested.

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Medicaid facts and figures for the practicing physician

By Elmer E. White
***Special to* Michigan Medicine**

In general, people agree that no one should be without needed medical attention.

In general, people agree that everyone should be paid fairly for goods and services provided.

But when people realize the cost of Medicaid, the program which promises complete medical care to all those unable to pay for it, has grown from $228.3 million to 1970 to $811 million in 1977, and that residents of the state will foot an important part of the rapidly-expanding bill, people look for ways to control the costs.

It is easy to blame the local doctor and try to limit his part in the costs. He is the one who sends the bill.

Many doctors feel a growing uneasiness when Medicaid is mentioned in conversation in their offices, in social situations or at community functions. It is apparent that most people do not understand either the problem or possible solutions.

Information here is meant to help the doctor explain the situation — not only so that people in the community will have a new and better understanding and hopefully react logically to their government officials, but also for the benefit of the doctor who has had too little time to seek out the facts for himself.

> ***The basic problem with Medicaid can be stated in simple terms:***
>
> ***The government promises everyone who needs it medical care under a program it is not willing to finance.***
>
> *– David Siegel, MD*

The basic problem is very simple. It is defined by David Siegel, MD, chairman of the MSMS Medicaid Liaison Committee. Doctor Siegel, an articulate, forceful advocate of changes to improve Medicaid, boils it down to the minimum.

He says that the state promises the public it will provide medical attention, but refuses to make adequate funds available to pay for the service.

"If the state were to finance roads on the same basis, it would promise an expressway from Detroit to the Bridge, then tell highway builders they are obligated to build it for an amount well below adequate cost. We'd be driving on a lot of dirt roads," Doctor Siegel declares.

Fraud in Medicaid, abuse and misuse are factors, but the basic concept of the state, says Doctor Siegel, is a sham on recipients or physicians or both.

MSMS has urged the state to be more aggressive in rooting out misuse of Medicaid funds. The Society has members on a new medical audit committee to review suspected cases.

So far, the state has submitted no cases for consideration.

Robert C. Bonhag, who holds a doctorate in dental medicine and a master's in health administration, is director of the Bureau of Medical Assistance. This is part of the State Department of Social Services which is headed by John T. Dempsey, PhD. Ultimately, the program falls under the responsibility of Gov. William G. Milliken. All of these officials show much interest in Medicaid problems.

Doctor Bonhag says he understands the need for more funds, but is charged with paying for services billed according to state-set policies and funds. The Governor and Doctor Dempsey say they want Medicaid to work, but are reluctant to find adequate funds when the budget shows signs of falling woefully short.

State officials have reduced expenditures by the questionable methods of arbitrarily paying no more than the doctors' fees charged in 1974 even though the service is performed in 1977, and by reducing this amount "temporarily" by 11%. The temporary aspect of this reduction shows signs of becoming permanent.

The state advanced another money-saving idea: any Medicaid patient whose length of stay exceeds 75 percent of the average length of stay would be required to pay a portion of his/her own bill. Additional costs would be borne by the doctor or hospital caring for the patient.

If Medicaid funds actually are depleted, Doctor Bonhag told this re-

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Mr. White recently retired after 21 years as executive secretary of the Michigan Press Association.

MEDICAID/*Continued*

porter, he would have no other course than to cease issuing monthly cards for Medicaid care. This would bring the program to a halt, but would precipitate a crisis both for patients and for those in the health care field who feel conscience-bound to provide medical care for those who need it.

A possible source of more funds for Medicaid without increasing taxes at the state level, might be for a larger portion of income to be budgeted for social services. Most likely these funds would be diverted from monies now appropriated for education. Such an action would certainly find substantial opposition from professional educators and quite likely from many parents and students who are anxious that the best possible education be provided. The fact that a growing number of people are developing the hunch that there is much waste in funds allotted for college education might help make the change possible.

Doctor Bonhag, while agreeing that something ought to be done to reduce fraud and abuse, also indicates that these issues are not great factors. He said he thinks that if all fraud and abuses were eliminated, it would save the state only two or three percent, not enough to solve the Medicaid financial problem.

Doctor Siegel believes much can be done easily and effectively to sort out fraud if the state would only get at it.

Computers could quickly identify offices where Medicaid charges are high, he says. "When most bills run $7," says Doctor Siegel, "and the state gets a stack of bills from one office which average $56 each, there should be some investigation at once." Doctor Siegel objects to the idea that all doctors should be investigated all the time. Such programs are expensive to administer and do not solve the problem, he says. Investigations bother the 98% of doctors who are functioning the best they can without dealing effectively with the very few who abuse the program.

The state's record for punishing offenders is not very dynamic. The *Detroit News* did a series on Medicaid and reported that "Michigan physicians convicted of stealing health care dollars usually continue to practice — with only brief interruptions — because of a reluctance by state professional licensing boards to deprive them of their livelihoods."

As of this July, the *News* had found only six physicians (five osteopaths, one MD) who had been convicted of violations in federal court. All continue to practice. One had his license suspended for six

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Points to Pass on to Patients . . .

and others who should know about Medicaid

Because nearly everyone identifies the doctor as the supplier of medical care, and the one who sends a bill to cover it, and because the very few exceptional abusers of Medicaid get much attention in the media, people tend to think that doctors are to blame for high health care costs.

MSMS members can make a good case to show physicians are not culprits in the Medicaid program by informing everyone of basic facts. Some of these are:

(1) Physicians receive only 15.8¢ of the Medicaid dollar.

Fraud and abuse of Medicaid are not large factors in the total bill. Nonetheless, MSMS urges strong state efforts to eliminate them and realize the savings possible.

Michigan has a model Medicaid program whose integrity is cited before other states by the federal government.

(2) Primary care doctors often care for Medicaid patients at an actual loss to themselves.

(3) Doctors are paid according to a formula set by the state. At present this is 11% less than what physicians received for the same service in 1974, though other formulas may be in effect by the time you read this article.

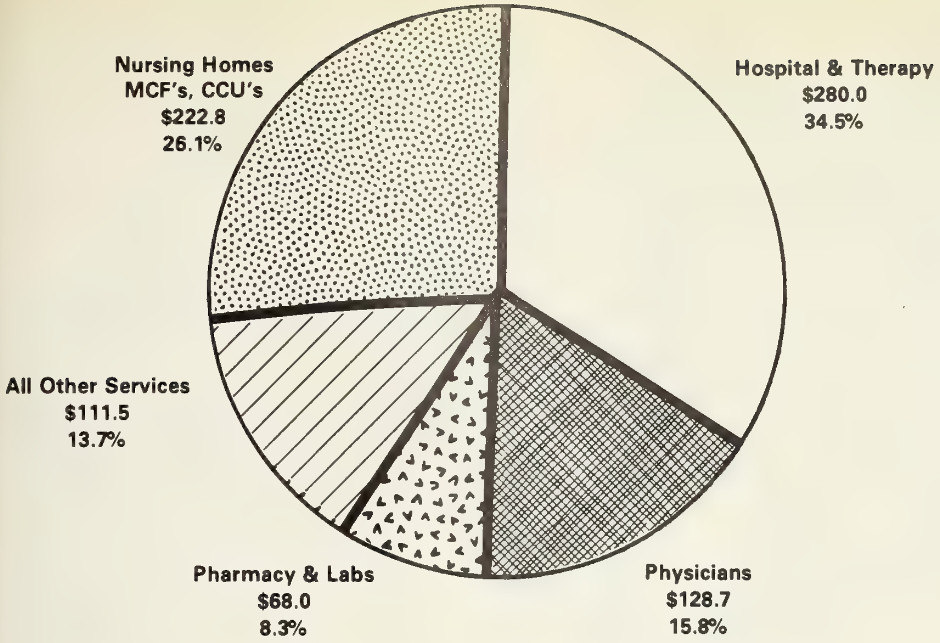
(4) Most physicians are not aware, once patients are admitted to the office, which are Medicaid recipients and which pay for care through other methods.

MSMS has pleaded with the state for stricter enforcement to reduce fraud and abuses, but has had little cooperation. MSMS has members on a medical audit committee to review charges in cases where abuse is suspected. Thus far, no cases have been referred to the committee.

The public may have to decide soon if it is willing to pay for the present program by paying higher taxes in some form.

(5) Fewer doctors are willing to accept Medicaid patients (except for emergencies), but they make this decision with sorrow and frustration over a system which sometimes seems unfair to them.

(6) Doctors can document cases where Medicaid does not pay out-of-pocket MD costs for drugs administered.



1976-77 MEDICAID BUDGET
(Millions of Dollars)
Total Funds — $810.8

This chart from the Michigan Department of Social Services shows the increase in percentage of state funds allotted to social services from fiscal years 1966-67 to 1976-77. During this same period, expenditures grew from $66,809,910 to $811,000,000. The number of average monthly medical assistance eligibles grew from 339,155 in 1967-68 (the first full year records could be kept) to a projected 996,645 in 1976-77.

months. Others had longer suspensions, but are practicing while appeals continue. State officials say that if they put doctors out of business the physicians will lose their ability to pay fines or repay for overbilling. Doctor Dempsey says that licensing review boards are overworked and understaffed; that they are reluctant to deprive someone of a livelihood.

One of the common lay beliefs is that physicians get most of the Medicaid pay outs. But how much do doctors get out of the total Medicaid dollar? Plans for 1976-77 call for a total expenditure of $810,829,939, virtually $811 million, with $407,524,069 coming from the federal government.

Of the total amount, all physician services are budgeted at $128,700,000. This figures out to be 15.8% and demonstrates that there are other large factors in the Medicaid expense.

Largest of these is the cost of hospital services and therapy: $280 million, or 34.5% of the total budget. Pharmaceutical expenses take another $68 million, or 8.3% of the Medicaid dollar. Auxiliary medical services consume $58.5 million, or 7.2%. Chronic care and county units get another $59 million or 7.2% of the total. Nursing homes, with that cost of $212.3 million, get 26.1% of the budget.

For anyone who looks at the entire picture, it becomes clear that doctors are not culprits who run up Medicaid costs; that there are other factors which contribute greatly to the total expense.

MSMS members can take pride in the record of their professional organization. They should point out emphatically that MSMS has taken strong stands to make Medicaid more beneficial for the patient and at the same time a more workable alternative for the doctor. People should be reminded that there are numerous providers of medical services. These include medical doctors, osteopaths, chiropractors, podiatrists and others. The list also includes laboratories, x-ray centers, ambulances, and pharmaceutical points.

While a very few doctors suspected of abuses or cheating the Medicaid program get much media attention, a very great number of MSMS members provide the bulk of the Medicaid service for nominal fees — or even at a loss.

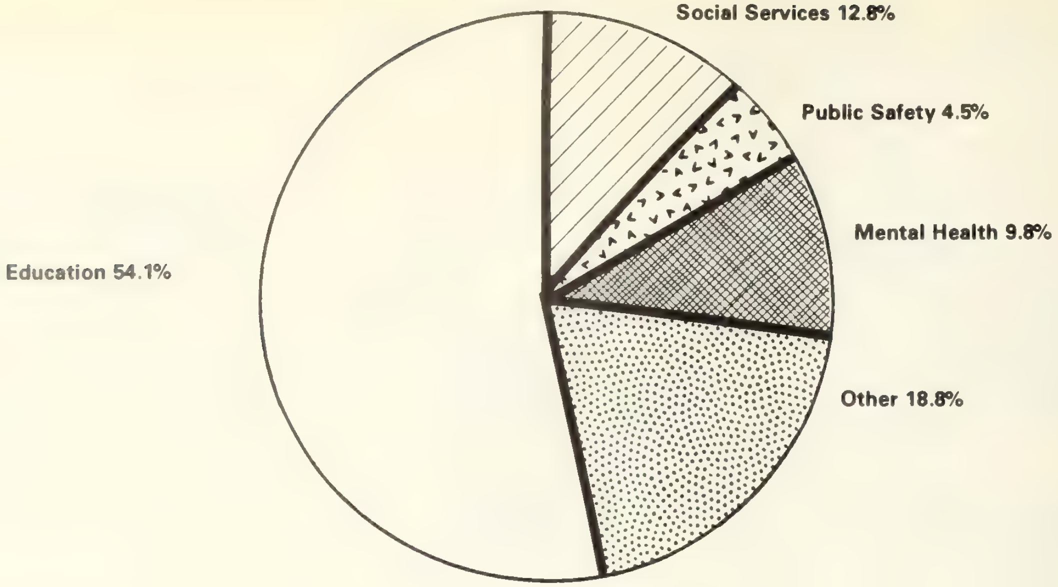
James D. Johnston, MD, Traverse City pediatrician, wrote Doctor Bonhag of the Bureau of Medical Assistance, about this subject last August. Doctor Johnston explained: "For instance, a recent cost accounting in our office shows that it costs us $7.95 to see a patient for which we charge $10. Medicaid pays us, if all goes well with the claims system, $7.12." He went on to report that physicians of his community are getting more and more disenchanted with Medicaid.

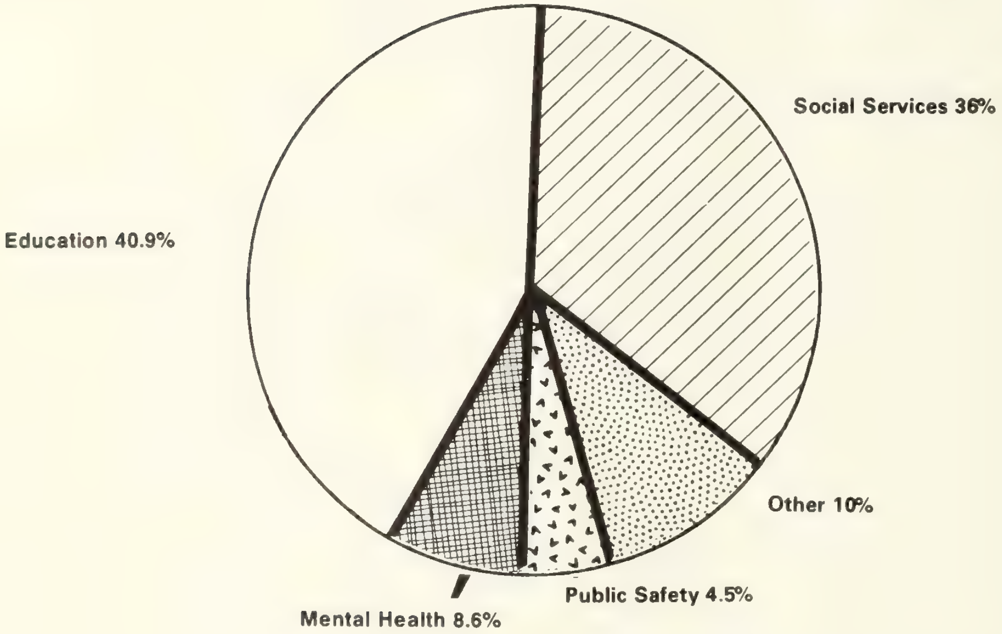
Doctor Siegel emphasizes the position of doctors who perform their services at an actual loss, saying, "To lose money is one thing, but to be besmirched in the media at the same time is almost too much to bear."

A recent study by MSMS shows that fewer MDs are willing to accept Medicaid patients than in 1973 when a similar study was made. This year out of 1,919 MDs who reported they accept new patients, 1,311 physicians (68.3%) responded they would accept new Medicaid patients. This is a drop from the 83.5% in the 1973 study.

Sources of most dissatisfaction, according to frequency of mention in the 1973 survey are these:

(1) the amount MDs are paid for their services
(2) patient abuse and overutilization of services available


BUDGET ALLOCATION
1966-1967


1976-1977

Physicians are paid only 15.8% of all dollars expended for Medicaid recipients, according to figures from the Michigan Department of Social Services. Percentages allotted to other Medicaid providers are indicated.

(3) extensiveness of the claim form and the bureaucracy physicians must deal with

(4) arbitrary rejection of claims and delay of payment

(5) extra administrative cost to work with the program

(6) government intervention in medical care

It is apparent that questions must be answered very soon. How will the promised medical services of the people in Michigan be paid for equitably? Or must there be a confrontation between those who promise medical service, those who provide it and those who are charged with providing funds for the services promised?

Doctors can help by keeping aware of the situation as it changes and by defining the issues articulately for the benefit of patients and others with whom they come in contact.

In the final analysis, Medicaid expenditure is not a doctor's problem alone. It is a problem of the people of Michigan.

Medicaid has grown enormously since its inception some 10 years ago. Before the expense reaches the $1.5 billion projected by the Michigan Department of Social Services for 1981-82, the public will become more aware of the program, the legislature must face up to appropriations required by it, or the state administration must redefine its policies.

How the privacy act affects one program

By David P. Gage, MD
Lansing

The Privacy Act of 1974 became effective on Sept. 27, 1975. Since physicians in Michigan supply vital information to the Social Security Administration to determine eligibility for disability and/or supplemental security income (formerly Department of Public Welfare assistance), it would help the physician to understand how the Act applies to social security disability cases.

In general, the Privacy Act reaffirms the confidentiality of social security records, while instituting changes related to an individual's right to all records about him including medical records and the right to request correction or amendments of the record. The amendment may take the form of corrections of inaccurate information, removal of items of information which are no longer relevant or timely, or the addition of information to supplement incomplete information.

In view of the confidential nature of such information, the request and authorization must be in writing, signed and dated by the individual.

Upon request for disclosure of medical information, the individual will be asked to designate in writing a representative through whom medical records may be disclosed. Such a representative should be willing to receive medical information and to discuss it with the individual.

Doctors to be involved

It is anticipated that in practically all cases, this individual will be the applicant's private physician. However, a non-medical representative may be designated. The medical records will be reviewed by an official in the employ of the Social Security Administration to determine that direct disclosure of this information will not be likely to have an adverse effect upon the individual. If the reviewing official should determine that direct disclosure of the medical information would be likely to have an adverse effect on an individual, or it cannot be determined by reviewing the records that direct disclosure may have an adverse effect, the medical information will be sent to the designated representative rather than the individual.

The number of requests from individuals to inspect medical reports obtained in connection with their disability claim is relatively small. In a great majority of requests the individual will already be aware of much of the information in his medical record.

Another change under the new act regards confidential or restricted information. No pledge of confidentiality may be given to the third party, including medical sources providing information to the Social Security Administration about the individual, except in investigative and possible fraud situations. Therefore, medical information should not be forwarded to the Social Security Administration with restrictions or "confidential" annotations.

The new disclosure of information provisions do not change the way physicians should complete medical reports in connection with the patient's disability claim. As always, the emphasis is on the type of objective reporting — that is, symptoms, signs, and laboratory findings relating to the patient's condition that is required for impartial disability determination under both programs. It is important to include pertinent negative findings as well as positive findings in the report. If certain laboratory proceedings or X-rays are deemed advisable, but are not available, a statement of this fact would be helpful regarding further evaluation.

The medical report should be sufficiently complete so that medical consultants can draw a firm conclusion from the positive findings to determine whether the individual meets the requirements for disability as set forth in the Social Security Act. Although the treating physician may not always agree with the decision, it must be realized that requirements are set by law and all the Social Security Administration can do is follow the law as passed by Congress.

No opinions needed

Since the decision of disability is based on objective medical evidence only, and not opinion, the physician should refrain from stating opinions in the report. The reporting physician should keep in mind that not only are opinions not a basis for determinations, but, should the individual request a copy of medical evidence used to prepare the decision in a case, the opinion included in the report will be part of the information released.

In this brief article, we have discussed the major changes in the Social Security Disability Program brought about by the Privacy Act and restated the important underlying principles of the disability program. The importance of prompt, complete medical reports cannot be over-emphasized.

With prompt, complete medical reports initially, the necessity of recontacting the physician and utilizing his or her valuable time obtaining additional information can be eliminated.

Doctor Gage has been chief medical consultant for Social Security Disability in Michigan for the past 17 years. He retired from the post this fall.

Heartbeat

By Mert Scholten
MSMS Communications Department

Larry E. Braak, MD, Marquette, has been appointed medical director of the Upper Peninsula Alcohol and Substance Abuse Center. A graduate of the University of Michigan Medical School, Doctor Braak has been active in substance abuse programs and serves as a member of the board of directors of a local halfway house for alcoholics. He will maintain his private practice in family medicine while directing the center.

* * *

Ronald L. Krome, MD, Southfield, has been elected to a four-year term on the American Board of Emergency Medicine (ABEM). Doctor Krome is director of the emergency department of Detroit General Hospital and is an associate professor of surgery at WSU School of Medicine. ABEM has the responsibility for developing and administering the certification examination in emergency medicine. The first test is planned for the fall of 1977.

* * *

Douglas A. Mack, MD, Sturgis, is new medical director of the Kent County Public Health Department. Doctor Mack previously served as medical director of the Branch-Hillsdale-St. Joseph and Cass County health departments. He will take over the Kent post in January.

* * *

J. Edward Manning, MD, Saginaw, was named an "honorary alumnus" of Michigan State University during MSU's October homecoming weekend. Doctor Manning was being honored by the university for his contributions to medical education programs as director of general surgery for Saginaw Cooperative Hospitals.

Robert J. Priest, MD, Detroit, was named president of the American Medical Writers Association at the group's national convention held in Detroit in October. He succeeds Doctor Ned Chalat in the post.

* * *

Robert E. Rice, MD, Greenville, recently elected chairman of the MSMS AMA delegation, was honored by his hometown for his 30 years as the school's team physician. The local paper reported the story saying: "Dr. Robert Rice was surprised at halftime Friday night (Oct. 1) when Greenville Board of Education president Dolores Cook announced that the new middle school gymnasium will be named after Rice. The halftime was devoted to honoring Rice, who has been the Yellow Jackets' team physician for 30 years. During the ceremony Rice received a plaque from the board, a television antenna from the student body and a letter of commendation from the Michigan High School Athletic Association.

Lewis D. Rickman, MD, Mt. Clemens, was honored recently for his more than 25 years of public service to his community. Townspeople gathered for a testimonial dinner held at the Hillcrest Country Club. The 57 year-old physician is a graduate of Meharry Medical College and has been in private practice in Mt. Clemens since 1950. He served 16 years on the Mt. Clemens Board of Education and has been active in the CME Methodist Church, YMCA and the Macomb County Unit of the NAACP.

* * *

Lewis E. Simoni, MD, Flint, has been named as a MSMS representative to the SHOTS task force to replace John Moses, MD, who resigned upon moving to Akron, Ohio. Other MSMS members of the task force include Harold E. "Pat" Crow, MD, Lansing, and Lee B. Stevenson, MD, Farmington.

* * *

Russell Smith, MD, Whitmore Lake, has been appointed Chairman of the MSMS Committee to Assist Impaired Physicians. He has been a member of the committee since its inception. He succeeds H. Richard Henderson, MD, who relinquished the chairmanship due to the press of other medical activities. Doctor Henderson remains as a member of the committee.

* * *

Alexander J. Walt, MD, Detroit, has been elected President of the American Association for the Surgery of Trauma for 1976-77.

Among MSMS members to be featured recently on "Focus," the WJR-Detroit radio interview program, is Louis E. Heideman, MD, right, MSMS Councilor and chairman of the MSMS Commission on CME. Doctor Heideman and "Focus" host J. P. McCarthy discussed the new requirements for physicians' continuing education.

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New Michigan Blood Council needs physicians' help

By Judith Marr
Managing Editor

Michigan physicians can play a vital role in assuring the success of the now-forming Michigan Blood Council.

The council will unite all Michigan blood collection and distribution services as part of a nationwide regionalization movement.

The drive for regionalization began with a HEW-promulgated federal policy for blood collection which will assure that the quantities and types of blood needed are close to the populations needing them. The federal policy was published in the Federal Register approximately two years ago.

Doctors should be aware

Physicians first should be aware of the organizational work being done to regionalize blood banking services and knowledgeable of the new regional system so that they can use it to their patients' best advantage, says Richard H. Danielson, PhD, assistant for program development, Bureau of Disease Control and Laboratory Services, Michigan Department of Public Health.

"In addition, we are asking several of the specialty societies to be represented on the Council once it is active, so they'll have the opportunity to help make policy throughout the new system's development," he says.

"Through their patients, physicians also are the most logical persons to promote the concept of the new system and urge public participation" adds Keith McCall, PhD, Chief, Division of Biologic Products, Michigan Department of Public Health.

"Blood donating more and more is viewed as a community responsibility," says Doctor McCall, "but literally 2-3% of the population is doing the entire job of donating."

"Physicians can play a critical role simply through brief talks with their patients," he continues. "Doctors can remind patients and families how immensely they benefit from the program."

Doctors also will be increasingly important to the accountability of the new regionalized blood bank program, assuring proper costs and efficiency and a good system, Doctor McCall points out.

The American Red Cross is the major blood collection agency in Michigan and thus has been responsible for accountability in the past, he says. With the new federal blood policy coming into play, much more detailed quality control conditions must be met, he continues.

"We will need a functioning medical advisory program for blood collection and distribution," he says. "In the past, it's been difficult to get doctors involved. Doctors need to contribute the views of local medical people and help change policies if necessary.

Doctor McCall believes this "long, chronic problem of non-cooperation" by physicians with the blood banking program has existed basically because "physicians didn't know their responsibilities in the first place.

"This whole program is moving on to bigger and better things (such as leukophoresis and plasmaphoresis)," he continues, "and it will require doctors' closer supervision."

MDs on ad hoc committee

An ad hoc committee on the regionalization of Michigan blood banking programs has been meeting a year and has now set the stage for the first organizational meeting of the Michigan Blood Council this month. Physicians on the ad hoc committee are: R. L. Carefoot, MD, Marquette; Edward Farber, MD, Midland; Joseph Mann, MD, Grand Rapids; A. William Shafer, MD, Detroit; and Richard Walker, MD, Royal Oak. MSMS will be one of 12 professional organizations to have a representative on the Council. Other Blood Council members will be drawn from the state public health department, blood collection and distribution professionals, organized labor and public organizations.

Michigan has a good background of blood banking programs which is unique for its dominance by the Red Cross, its total coverage of the state area, and its 98% volunteer blood donors, according to Doctor Danielson. Very few donors now are paid.

Purpose of the new Michigan Blood Council will be to assure and promote donor recruitment, inventory control, public and professional education, data collection and analysis, reference laboratory services and to seek accreditation as the regional organization for Michigan.

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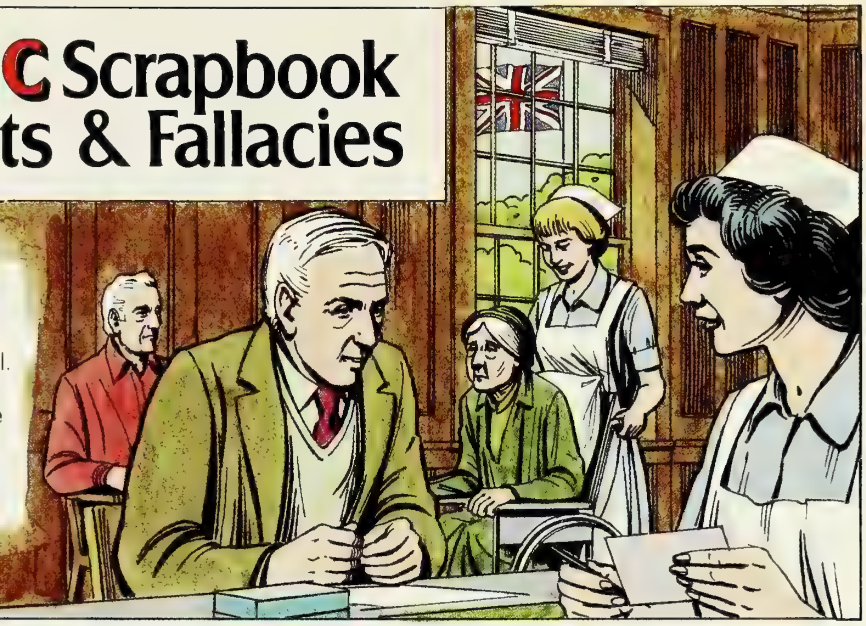
Griffiths, L.L., Brocklehurst, J.C., MacLean, R. et al. *Diet in Old Age*, Brit. Med. J., 1:739, 1966.



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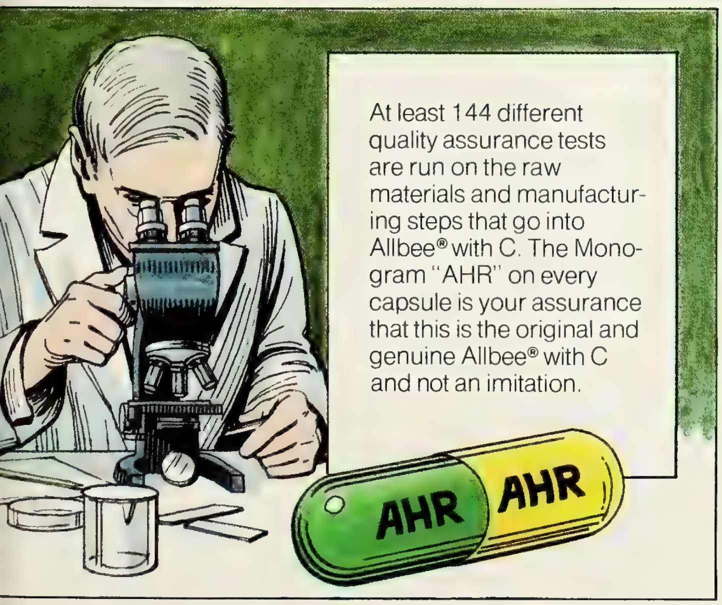

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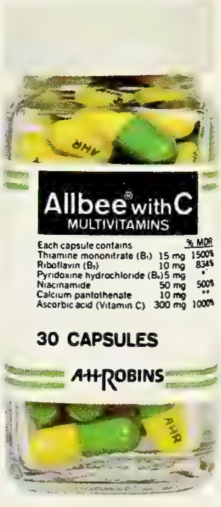

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What you should know – the Michigan Department of Public Health

The Michigan Department of Public Health has been concerned with the health needs of children since it was created in 1873. At that time, diseases, such as scarlet fever, diphtheria, and smallpox were so familiar that they were accepted as necessary features of childhood.

The importance of maternal health was recognized when statistics showed that from 1900 to 1912 one of every 100 mothers in Michigan died during childbirth. And one baby in eight died at birth or soon after.

To encourage good health practices and health care for mothers and children, public health nurses worked closely with both rural and city families. Classes on infant care were provided for new mothers. And clinics were established to provide medical care during and after pregnancy.

Over the years, the Bureau of Personal Health Services has expanded to meet increasing health needs. In addition to the central offices located in Lansing, there are five regional offices located in Marquette, Grand Rapids, Lansing, Detroit, and Pontiac.

The services of the bureau are divided into four areas: Maternal and Infant Health, Child Health, Crippled Children, and Health Care Projects.

Maternal and Infant Health

The Maternal and Infant Health Division is concerned with the health of mothers and newborn babies in Michigan. This division works with local health departments in helping provide care for women with a high risk of developing complications during and after pregnancy. These women are counselled and supervised by teams of health professionals consisting of an obstetrician-gynecologist, a public health nurse, a medical social worker and a nutrition consultant.

As a service to MSMS Members, *Michigan Medicine* begins with this issue publication of a series of articles describing the services of the Michigan Department of Public Health. Many of the services are directly available to Michigan physicians. All involve the doctor at least indirectly, and should be well-known to him or her. The following pages may be kept by MSMS members for handy reference to the state's public health services.

To improve nutritional standards and therefore improve the health of mothers and infants a special nutrition program provides counselling and food supplements to pregnant and nursing women, infants, and children to four years of age.

Medically indigent intercity mothers and children receive comprehensive health care through the Division's *Detroit Maternity and Infant Care Project.* Another special treatment program, the *Preschool, Adolescent, and School Age Project* (PRESCAD), provides comprehensive care for children in specific economically deprived areas of the State.

One of the oldest programs in the Maternal and Infant Health Division is the maternal mortality study conducted in cooperation with MSMS and the state's medical schools. Since the study began, maternal mortality has dropped from 5.0 per 10,000 to 1.4 per 10,000. Every maternal death in Michigan is reviewed and studied to gain information for use in preventing future deaths.

The Division also works with communities in planning and developing regional intensive care centers for newborns with special health problems.

Family Planning consultants work with local health departments, clinics, private physicians, private corporations, hospitals, and volunteer agencies in setting up and promoting family planning programs in local communities. These local programs provide complete physical ex-

MDPH/*Continued*

aminations, laboratory testing services, and counselling on contraceptive methods, venereal disease, sterilization, nutrition, and various other subjects.

The Family Planning Unit administers the funds for local programs and monitors and evaluates their services.

Child Health

The Child Health Division is concerned with finding children with abnormalities particularly of hearing and vision, and directing these children to sources of help.

The *Vision and Hearing* and *Speech* Sections train, certify, and supervise technicians from local communities to test children for possible problems. Over 850,000 kindergarten, preschool, and school-age children are tested each year. Those children found to have a handicapping or potentially handicapping hearing or vision loss are referred to an appropriate specialist or to otology clinics sponsored by the state health department. Mentally handicapped children are tested for disorders that may be adding to their mental retardation.

Children whose speech, hearing, or vision disorders are diagnosed as "crippling" handicaps may receive services through the *Crippled Children Program*. State health department consultants help local communities, county health departments, and school districts develop and maintain registers of visually impaired and hearing handicapped children. Hearing consultants authorize the purchase of hearing aids for children in need. And the hearing and speech section sponsors summer intensive therapy programs for selected children with cleft palate.

In an attempt to find children with abnormalities at the earliest possible time in their lives, the child health division began establishing *Early and Periodic Screening, Diagnosis, and Treatment* clinics in 1973. These clinics test Medicaid-eligible children for abnormalities and refer them to appropriate specialists. The clinics also provide screening and counselling for children and adults with the sickle cell trait or sickle cell anemia.

Division consultants review proposals and authorize funding for local and regional developmental disability projects. These projects provide services such as sheltered employment, training, counselling, recreation, and transportation for the developmentally disabled.

Two projects, administered by the Division, provide team appraisals of children who have multiple handicaps. Teams of health professionals evaluate each child, then recommend and begin a specialized treatment plan.

The Child Health Division also studies the causes, consequences, and possible prevention of SIDS or sudden infant death syndrome; assures that all newborns are tested for PKU, and trains professionals in the care of mentally retarded children.

Crippled Children

Crippled children include not only those children who have a bone defect or deformity, but also those youngsters with a heart condition, a cleft lip or palate, cystic fibrosis, hemophilia, or any of a long list of diseases, birth defects, and injuries. The Department's *Division of Services to Crippled Children* is required by law to locate and serve those people under 21 years of age in need of health services for their crippling or potentially crippling conditions.

To find children with suspected crippling conditions, staff members review over 80,000 hospital admission and discharge reports of Medicaid covered children each year. These children are referred to state-approved specialty clinics located in the out-patient departments of community hospitals or to diagnostic field clinics provided by the department where they receive free diagnostic services. A major part of the diagnostic services is counselling for the parents. If a crippling diagnosis is established, the child is given an individual plan of specialty treatment. Families may receive financial help in paying all or part of the costs.

Division staff members certify hospitals where crippled children under Medicaid receive care; authorize payments to health care specialists; conduct field clinics; and review treatment plans for children with complex problems.

Health Care Projects

The *Division of Health Care Projects* administers a variety of programs aimed at upgrading the health of specific groups of people in certain areas of the State. This division provides consultation to comprehensive health care projects in both rural and urban areas. Two such projects, the Community Health and Social Services Project in Detroit and the Lakeside Clinic in Pontiac, operate as full service clinics. Both projects provide health screening services for children and adults, social services counselling, and health education to those people financially unable to seek health care.

A network of clinics reaching across Michigan's lower peninsula provides out-patient health care services to migrant agricultural workers. In cooperation with the Inter-Tribal Council of Michigan the Division employs, trains, and supervises community health representatives to work with Indian people who do not live on reservations.

In addition, the Division allocates funds for two physicians located on Mackinac and Beaver Islands.

These programs of the Bureau of Personal Health Services are some of the many services provided by the Michigan Department of Public Health. Other program areas will be covered in future issues of this publication.

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Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

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Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

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Letters

"This . . . is very important to every physician . . . likely to be contacted concerning DES in utero."

The subject of diethylstilbestrol (DES) exposure *in utero* is a familiar one to members of the Michigan State Medical Society. You may know that the National Cancer Institute's Division of Cancer Control and Rehabilitation is directing a study in four institutions, called the DESAD project, of DES-associated vaginal and cervical irregularities and the rare instances of clear-cell adenocarcinoma that occur in DES-exposed daughters.

A new report entitled *Information for Physicians – DES Exposure in Utero* has been compiled by the physicians of the DESAD Project's Professional and Public Relations Subcommittee, and edited by the Office of Cancer Communications of the National Cancer Institute.

This information is very important to every physician in this country who is at all likely to be contacted concerning DES exposure *in utero.*

The pamphlet answers questions physicians and patients are now asking. The DES-type drugs that may have been prescribed to pregnant women are listed. A bibliography is included. Among the questions are:

What is diethylstilbestrol (DES)?

Why were DES-type drugs used in pregnancy?

What is the cancer problem associated with *in utero* exposure?

What noncancerous irregularities occur with this exposure?

If the patient was exposed to DES-type drugs, what should be done?

What about followup examinations?

What is the management of vaginal and cervical irregularities other than clear-cell adenocarcinoma?

Where do the cancers that have been diagnosed occur?

What is the therapy for these cancers?

This *Information for Physicians* pamphlet is available at no cost from the National Cancer Institute's Office of Cancer Communications, Bethesda, Maryland 20014.

Thank you very much for your cooperation.

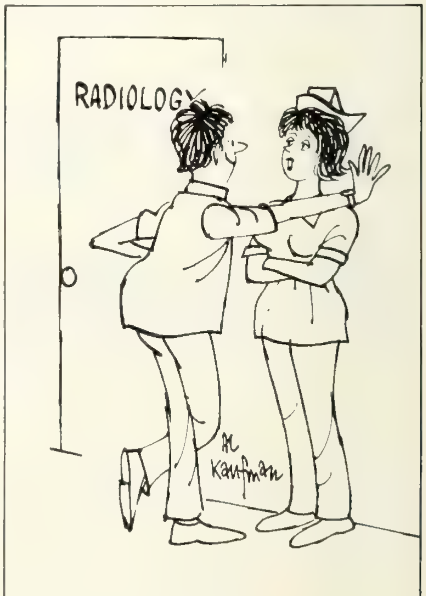
Sincerely yours,

Frank J. Rauscher, Jr., PhD
Director, National Cancer Program
HEW Public Health Service
National Institute of Health
Bethesda

"I would like to correspond . . . "

I am currently engaged in research on the Munchausen (Hospital Addiction) Syndrome and it's variants. I would like to correspond with any other physicians who have had personal contact with such patients. To this end I would appreciate it if you would print this letter in your Correspondence (or Letters) section. All responses to be addressed to:

S. E. Hyler
5620 Netherland Avenue
Riverdale, New York 10471



"I can see right through you, Bruce."

Meetings

(See also Category I Courses on page 698)

December 11 — December Seminar, "Lesions of Salivary Glands," Michigan Society of Pathologists, at Rackam Auditorium, University of Michigan, Ann Arbor, contact: John Dunkel, MD, MSU, Dept. of Pathology, Fee Hall, Room 677, East Lansing 48824

December 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

January 12 — Michigan Dermatological Society regular meeting at Providence Hospital, contact: Richard F. Elton, MD, 15901 W. Nine Mile Rd., Southfield 48075

January 19 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

Jan. 20-23 — AMA Leadership Conference, Chicago, contact: Warren F. Tryloff, MSMS director

January 23-February 1 — MSMS/INTRAV Trans-Panama Canal Air/Sea Cruise, contact: Marce Ireland, MSMS Headquarters

February 9 — Michigan Dermatological Society regular meeting, at Henry Ford Hospital, Detroit, contact: Richard F. Elton, MD, 15901 W. Nine Mile Rd., Southfield 48075

February 12 — February Seminar, "Bleeding Disorders and Thromboembolic Diseases" sponsored by the Michigan Society of Pathologists, at Henry Ford Hospital, contact: John F. Dunkel, MD, MSU, Dept. of Pathology, E. Lansing 48824

March 2 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

March 9 — Michigan Dermatological Society regular meeting, at University of Michigan, Ann Arbor, contact: Richard F. Elton, MD, 15901 W. Nine Mile Rd., Southfield 48075

March 30 — MSMS Auxiliary Legislative Day, at Olds Plaza Hotel, Lansing, contact: Helen Schulte, MSMS Headquarters

April 20 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

April 19-21 — International Symposium on "Human Ovulation," at C. S. Mott Center for Human Growth and Development, Wayne State University School of Medicine, Detroit, contact: Dr. E. S. E. Hafez, C. S. Mott Center

May 6 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

May 14 — May Seminar, "Lymphoreticular Disorders, sponsored by the Michigan Society of Pathologists, at Hurley Hospital, Flint, contact: Jacob E. Briski, MD, Saint John Hospital, 22101 Moross Rd., Detroit 48236

May 13-15 — MSMS House of Delegates 1977 Annual Session, Troy Hilton, Troy, contact: Richard Campau, MSMS Headquarters

June 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

June 18-22 — AMA Annual Convention, San Francisco

Percent of Specialists in Michigan who are MSMS members

MSMS Bureau of Economics

SPECIALTY	MSMS MEMBERS*	MDs IN MICHIGAN	PERCENT
Allergy	74	83	89.2
Anesthesiology	302	348	86.8
Dermatology	130	132	98.5
Family Practice	1,589	2,381	66.7
Gastroenterology	39	47	83.0
General Surgery	792	987	80.2
Internal Medicine	1,240	1,552	79.9
Neurological Surgery	66	74	89.2
Neurology	56	77	72.7
Obstetrics-Gynecology	670	769	87.1
Ophthalmology	292	329	88.8
Orthopedic Surgery	252	262	96.2
Otolaryngology	131	157	83.4
Pathology	267	357	74.8
Pediatrics	404	564	71.6
Physical Medicine	139	200	69.5
Plastic Surgery	55	56	98.2
Proctology	22	28	78.6
Psychiatry	504	802	62.8
Radiology	403	499	80.8
Thoracic Surgery	79	97	81.4
Urology	165	181	91.2
TOTAL	7,671	9,982	76.8%

** Excludes retired and associate members.*

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Practice Management

New tax law revisions and how they affect physicians

By Edwin V. Ritzler
Battle Creek

The Tax Reform Act of 1976 has instituted sweeping changes in tax law which will affect most if not all doctors, according to tax attorney John A. Campbell, Esq. of the law firm Brown, Colman & Dement, Kalamazoo, Mich.

Speaking to the recent 1976 annual continuing education seminar of the PM Group, Mr. Campbell detailed major features of the new law as they impinge upon medical and dental practitioners. Following is a summary of his remarks:

The changes in the area of tax shelters are extensive and generally either tighten or eliminate the present tax advantages of certain shelters.

Depreciation

The excess of accelerated depreciation over straight-line depreciation will be recaptured when real estate is disposed of, effective for the years following Dec. 31, 1975. The only real estate depreciation which is not recaptured is for government subsidized housing, and this exception expires in 1982.

Construction period interest and real property taxes

In the past, property taxes and interest could be deducted during periods of construction. This deduction has been eliminated except for residential property for 1976. All other construction period interest and property taxes will be capitalized and amortized if construction began after Dec. 31, 1975. You are allowed a deduction for 1976 of 50 percent, the balance to be amortized over a three-year period.

After 1977 the construction interest and taxes will have to be capitalized for all types of real property, including residential real property.

Farming, oil, movies, and equipment leasing shelters

For all practical purposes, the shelter advantages of syndicates in these areas are over and done with. For 1976 and all subsequent years, deductions will be limited to the amounts "at risk" in the venture, i.e., loans for which the taxpayer is liable. An exception is movies begun by Sept. 10, 1975.

In the case of petroleum exploration, intangible drilling costs can still be deducted. However, such costs incurred and deducted after Dec. 31, 1975 will be recaptured when the taxpayer sells his interest in the syndicate.

Under the new law, feed, fertilizer, seed, and other expenses of farm syndicates are deductible only in the year utilized, not when purchased. This applies to all syndicates beginning in 1976 unless the activity was in existence in 1975. Included under this part of the law are developmental costs for orchards or groves, which must be capitalized.

It is important to note that the term "farming syndicate" can include one taxpayer if he does not actually manage the farm.

Prepaid interest

Instead of deducting interest paid for several years in advance, interest deductions can now only be taken when the interest is actually due. For example, if interest for 1977 is prepaid in 1976, the deduction cannot be taken until 1977.

The rule against deducting prepaid interest does not apply to amounts paid under regular business custom (points) or to amounts paid prior to 1977 under contracts in effect on Sept. 11, 1975.

Investment interest deduction

In previous times you were limited to deducting $25,000 in investment interest, plus your investment income, plus one half of the balance over that. This no longer applies. For all indebtedness incurred after Sept. 11, 1975, you will only be allowed to deduct $10,000 in investment interest, plus your investment income.

Partnerships

These changes apply primarily to syndicated partnerships — the old limited partnership.

Particularly dramatic are the changes in the treatment of organization fees, the fees paid to the syndicator, the fees paid to the accounting firm, and the fees paid to the legal firm for drawing up the partnership agreement.

Organization fees

The organization fees are deductible for 1975. However, for years ending after Dec. 31, 1976 they will have to be capitalized and amortized over a period of at least 60 months. These costs are typically the fees to the attorney for drafting the partnership document, and the fees for registering the partnership.

Syndication fees

These fees are no longer deductible; they must be capitalized effective with the tax years beginning after Sept. 31, 1975.

Income and loss

Allocation of partnership income and loss is now based upon the time the taxpayer is actually in the partnership. Previously, a new part-

(Continued on page 687)

Mr. Ritzler is with Black and Skaggs Associates, Inc.

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> WARNING
> This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Preexisting elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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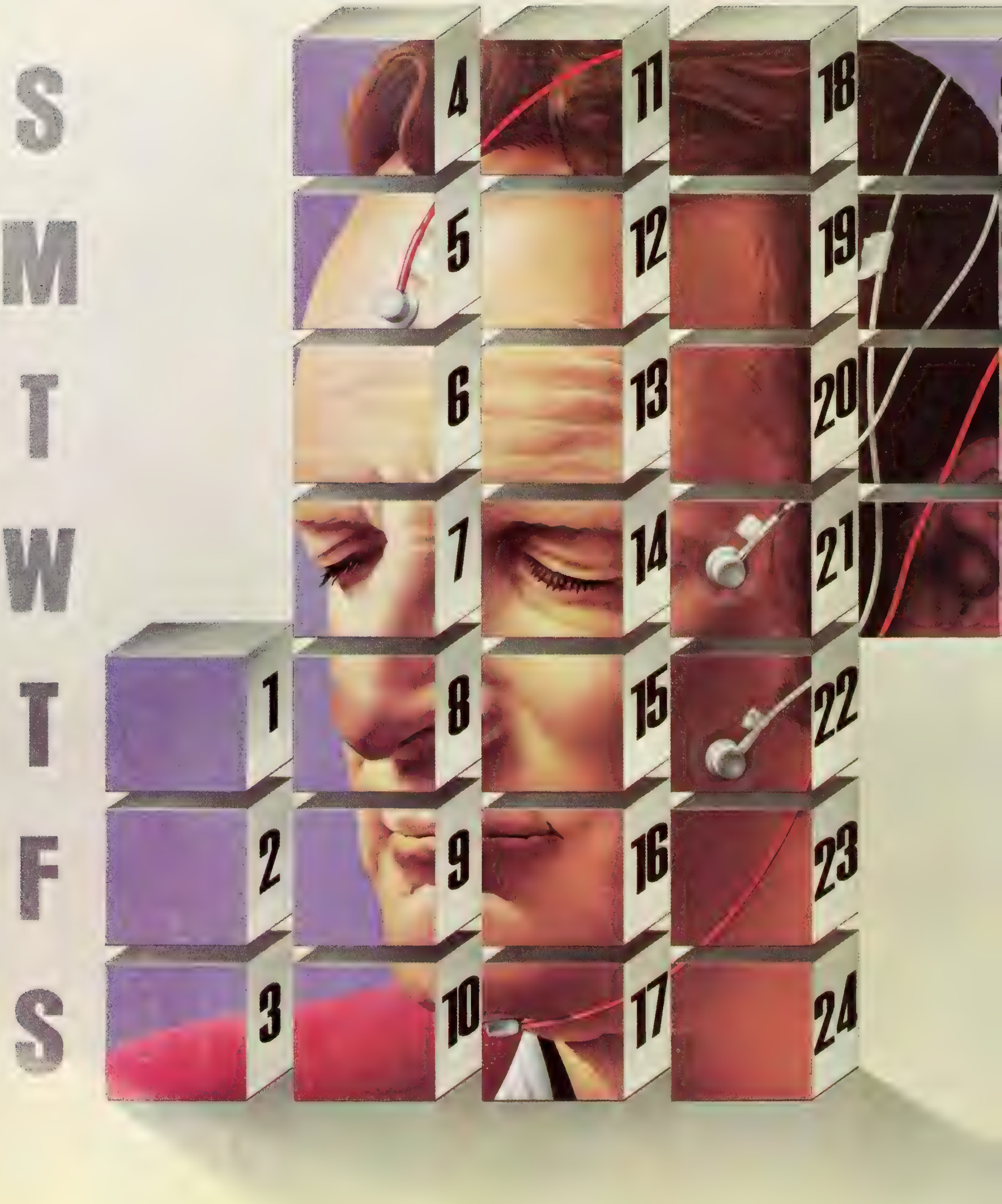
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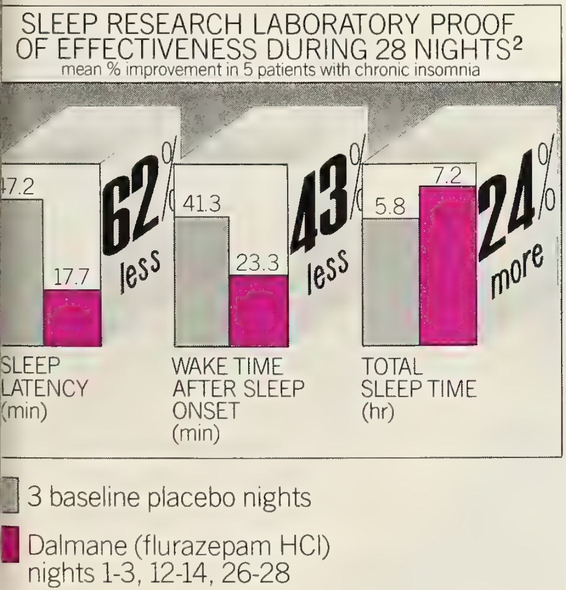
Since insomnia is often transient and intermit-
nt, the prolonged administration of a hypnotic is nerally not necessary or recommended. But when somnia is a chronic or recurring problem, ntinued effectiveness is as important as initial ectiveness. Results of a recently published sleep search laboratory study[1] demonstrated that, while ntobarbital lost effectiveness within two weeks, lmane maintained effectiveness for 28 consecu- e nights. Similar 28-night results with Dalmane, splayed below, were obtained by a second sleep search group.[2] In previous studies,[3] both chloral drate and glutethimide began to lose effective- ss after several nights, while Dalmane main- ned effectiveness throughout the 14 medication ghts. Whether the problem is difficulty falling leep, staying asleep or sleeping long enough, nsider these results when selecting a ep medication.


SLEEP RESEARCH LABORATORY PROOF OF EFFECTIVENESS DURING 28 NIGHTS[2]

mean % improvement in 5 patients with chronic insomnia

Patient benefits include relative safety, infrequent morning "hang-over"

Dalmane is well tolerated, seldom causing morning drowsiness or grogginess.[4] No increase in dosage is required for continued effectiveness from night to night.[1-3] Should Dalmane be used repeatedly, periodic blood counts and liver and kidney function tests should be performed. The usual adult dose is 30 mg *h.s.*, but 15 mg may suffice for some patients and is recommended as a starting dose for the elderly and debilitated to help preclude oversedation, dizziness or ataxia.

Continued relief of insomnia: One more good reason to specify

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

whenever a hypnotic is needed

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lease see following page for a summary of product information.

Objective proof: continued insomnia relief without increasing dosage...[1,2]

Dalmane®

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Objectively proved in the sleep research laboratory…

during 28 consecutive nights of administration:

- ☐ **effectiveness with a single 30-mg *h.s.* dose, maintained**
- ☐ **rapid sleep induction, maintained**
- ☐ **sleep for 7 to 8 hours, on average, maintained**
- ☐ **less time awake during the night, maintained**

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

> ***Usage in Pregnancy:*** **Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Kales A, *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975
2. Dement WC, *et al*: Long-term effectiveness of flurazepam 30 mg *h.s.* on chronic insomniacs. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, Jun 30-Jul 4, 1975
3. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
4. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

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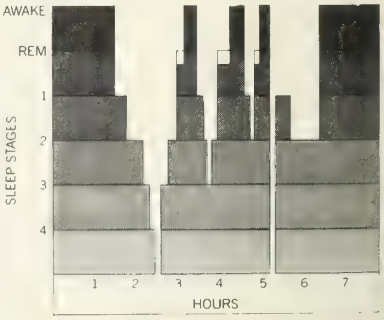

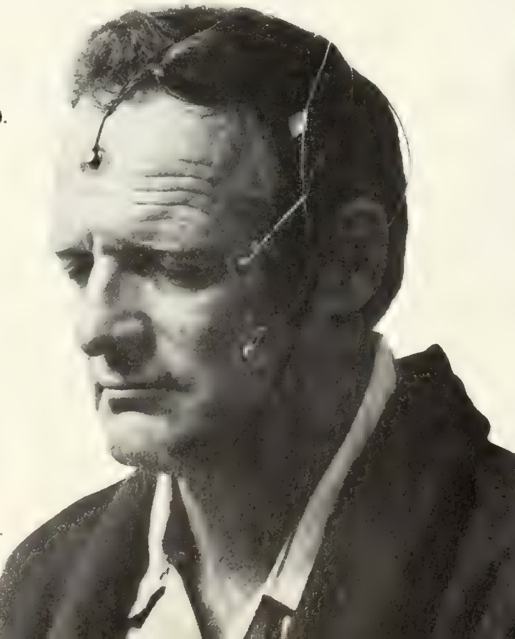

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ner might receive as much as a year's worth of losses no matter when he entered the partnership. A new partner as of Dec. 15, in any year, for example, is now limited to 15 days of losses.

Partnership liabilities

For all partnerships except syndicates involved in farming, oil exploration, movies, and equipment leasing, partnership liabilities will not be added to the partners' tax basis unless he is personally liable for the losses. This rule applies to liabilities incurred after Dec. 31, 1976, but does *not* apply to real estate. Basically, the good, old-fashioned real estate-apartment building shelter is still pretty much in effect.

Minimum taxes

Effective in 1976, there are three new tax preferences available to the taxpayer.

1. Itemized deductions in excess of 60 percent of adjusted gross income, excluding casualty losses and medical expenses.

2. Intangible drilling costs in excess of the amounts which would be allowed if you capitalized and amortized them over a period of 10 years.

3. The excess of accelerated depreciation over straightline depreciation on equipment leases.

The $30,000 minimum tax exemption which existed previously has now been reduced to $10,000 or one-half of your regular taxes, whichever is greater. There is no carryover of the prior year's taxes.

Maximum taxes

Income in this area was formerly called "taxable earned income." The new term is "personal service taxable income."

Included under the new definition is pension and profit-sharing income received after December 31, 1976. This will require very careful tax planning for the doctor who elects to receive income from a retirement plan on a non-lump sum basis, i.e., monthly payments.

Also, if you utilize tax preference items, these items will reduce your personal service taxable income on a dollar-for-dollar basis.

Business-related income

There are two significant changes in this area.

1. The deduction for an office in the home essentially has been eliminated. No deduction will be allowed unless the office is the regular place of business, or is used by patients in the normal course of business, or is a separate structure.

2. No deduction is allowed for vacation homes (including motor homes) if they are used for personal purposes more than 14 days or 10 percent of the total days the home is rented out, whichever is greater. Expenses are pro-rated based upon use.

Other deductions

The moving expense deduction has been increased for 1977 by an extra $1,000, and the 50 mile radius has been reduced to 35 miles.

Foreign trusts

The tax advantages of putting money in foreign trusts for your children have been eliminated. Any foreign trust created after May 24, 1974, or any addition to such a trust after that date, will now be taxed to the grantor rather than to the beneficiary.

Capital gains and losses

As of Jan. 1, 1977, the holding period for an asset to qualify as a long-term capital gain or loss has been extended from the present six months to nine months. In 1978 and thereafter the holding period is further lengthened to 12 months.

Estate and gift taxes

Though no changes in estate and gift taxation were expected this year, the new tax law contains what are probably the most sweeping alterations in this area since 1942.

Effective Jan. 1, 1977 there is a new unified estate and gift tax rate. The rate is the same whether it applies to an estate or a gift. We also have a new unified credit which exempts for all practical purposes by 1981 an estate of about $130,000 from estate taxation. In addition, complicated new rules have been established for calculating the tax basis of all persons dying after Jan. 1, 1977.

Lump sum distributions

A sleeper in the new tax law is the provision that lump sum distributions from a qualified pension or profit-sharing plan are now includible in the estate no matter who they are paid to, whether to the estate or a beneficiary. In other words, unless the distribution from the plan is paid out over a period of 36 months or more, it will be included in the estate and subject to estate taxation. This provision is effective January 1, 1977.

If your retirement plan presently calls for a lump sum distribution, it is vital that you sit down with your tax advisor and assess the consequences of this change in estate tax law. Otherwise your estate may one day be faced with a sizable tax levy that no one expected.

Marital deduction

The marital deduction has also been changed for both estate and gift taxes.

The estate tax marital deduction was formerly the greater of $250,000 or one-half of the taxable estate. Under the new law, all estates below $250,000 will be allowed to pass to the spouse totally tax-free.

The new gift tax marital deduction allows the gift of $100,000 to the spouse totally free of tax during the taxpayer's lifetime. Additionally, 50 percent of gifts to the spouse in excess of $200,000 will qualify as tax-free. The status of gifts between $100,000 and $200,000 is unclear and will have to be clarified in the future.

The extensive changes in the area of gift and estate taxes will require that most wills and trusts be reviewed by your attorney and tax advisor to determine whether they should be modified or redrafted to comply with the Tax Reform Act. Many thousands of dollars are at stake.

Foreign conventions

Finally, new rules for foreign conventions allow deductions for only two such meetings a year after 1976. Air travel to the meetings can only be deducted for the economy or coach fare. If you go first class you will not be allowed to deduct the excess of first class over coach. Only expenses for time actually spent attending the meeting may be deducted.

commentary

Michigan Indians need much in health care

Doctor Schneiter

By Harry E. Schneiter, MD Allegan

The Indian health problem, in the state of Michigan, is comprised of many interrelated factors.

The total number of Indians in the state of Michigan is approximately 30,000-35,000, of which only about 1,500 are located on reservations. The rest live in communities in almost a tribal relationship, with most located in the larger cities.

These ghetto-like conditions affect Indians' attitudes and living conditions very markedly. These people have a very basic distrust of white society, since they have been exploited for many years, primarily, and because of this distrust, they do not have ready access to the usual channels for medical care. In addition, very few Indians are involved in health careers. Consequently, they do not know what health resources exist or how to get at them. In addition, their educational level is extremely limited. According to recent figures, aproximately 73 have not graduated from high school and approximately 41% have not finished ninth grade. Because of these rather startling statistics, the level of unemployment is extremely high.

Because of their distrust of government and white people, Indians are not easily reached by the Department of Social Services, and do not have ready access to many of the programs that have been set up to help disadvantaged people.

It has been stated that these Native Americans are light-years behind Chicanos and Blacks, in obtaining the health services available in today's society.

Recently, a giant step forward has been taken with the recruitment of state-financed community health representatives to help alleviate some of the logistical problems. Michigan is the first state in the nation to provide community health representatives for off-reservation Indians. I should add that the on-reservation Indians are provided this service through various federal programs.

The function of these community health representatives is to assist in any way they can to alleviate these problems. Because they are of the Indian nation, they are trusted by the Indian people. Their training consists of both medical and sociological indoctrination, as exemplified by a recent seminar at Michigan State University which was sponsored by, in part at least, the Department of Family Practice. In addition, a proposal is being formulated through the College of Human Medicine at Michigan State University, to bring together the various disciplines represented in the school to set up a training program utilizing the local community college facilities. The program would help community health representatives so that they will be good representatives and have more basic knowledge, to enable them to improve their liaison function. During the recent conference at Michigan State University, sponsored by the MSU Department of Family Practice and Continuing Education Service, the Michigan Health Board and Michigan Department of Public Health, some 30 community health representatives benefited from a week of intensive orientation.

From the standpoint of Michigan medicine, the needs are many. Indian young people should be encouraged to obtain training in the health professions. Liaison needs to be set up with the Indian people, probably through the community health representatives, by the medical community so that the health reps will have access to interested physicians to assist in the care of the Indian people. Through local interest and availability, we hope many of the problems at least can be improved.

The Michigan Academy of Family Physicians has passed several resolutions through its Board of Directors endorsing the concept of established liaison with the CHR's and also endorsing educational programs for physicians' groups in the state.

A real need now is to arrange for speakers at county medical societies on the local level, to acquaint interested physicians with the local area health representatives, and also to give a better understanding of the many health problems which are indigenous to the Indian nation. If we are able to identify those physicians

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Doctor Schneiter is chairman, Indian Health Service, Michigan Health Care Commission, Michigan Academy of Family Physicians.

in the state of Michigan who are interested in the problems, we can develop a corps of health professionals who would be willing to exert some effort to help with the health needs and also assist in such a liaison.

There are a number of very interesting speakers available, both through the National Association of Indian Physicians, and locally in the state who are very conversant with the problems and have some very specific suggestions regarding solutions. Their appearances can be arranged through the Michigan State University Department of Family Practice, or through me. We would be most happy to arrange for the programs and can assure any interested medical society a most entertaining, as well as thought-provoking evening. This is an opportunity once again for Michigan medicine to be in the forefront of a very badly-needed program and, personally, I feel that I can assure the fullest cooperation from the leaders of the Indian nation. I can think of no more appropriate project in this, our Bicentennial year.

Second printing improves Uniform Claim Form

By John B. Bryan, MD
Royal Oak

Michigan *does* have a uniform claim form, as mandated by the Michigan State Medical Society House of Delegates. It is the result of diligent and constant cooperative effort by experts to develop forms and processing claims of the State Department of Social Services and Michigan Blue Cross/Blue Shield.

The members of the MSMS Committee on Uniform Claim Form and Coding Procedures working with these parties have been constantly aware of two equal requirements: (1) the carriers' need to develop a form

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Doctor Bryan is chairman, MSMS, Committee on Uniform Claim Form and Coding Procedures.

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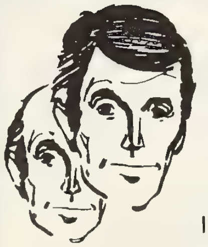

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COMMENTARY/*Continued*

which can be used by optical character recognition (OCR = computer scanning of claim forms, for rapid processing), and (2) the need of physicians and their staffs to have a simple and mechanically-adaptable form for preparation of claims. (It was recognized from the outset, though this was the initial goal, that the Uniform Claim Form developed by the AMA was not adaptable to OCR.)

All parties to development of this uniform "Michigan Medical Claim Form" were well aware that no amount of "field testing" would produce the needed "feedback" from those preparing claim forms. Carefully prepared instruction preceded intitial use of the "First Printing." And *Michigan Medicine,* June 1976 reproduced the two versions of the form and explained the differing needs of the state (for Medicaid) and BC/BS of Michigan (for regular business, not to include Medicare Part B, Champus, dental or drug benefits).

Since inception of use of the form on July 1, 1976, defects have come to light and prompted the MSMS committee to again work with BC/BSM and the state. Both parties *have* reworked the forms so that the "Second Printing" *will* be uniform (i.e., vertical alignment and positioning of data element boxes). The size of the data boxes has been increased to accept differing type and spacing. Color shading has been improved to indicate unnecessary elements and lining of boxes is clearer to highlight needed data.

Current supplies of "First Printing" will be exhausted and the "Second Printing" will be distributed to physicians' offices late in December 1976 or January 1977. Your MSMS committee has seen the final, printed drafts of the "Michigan Medical Claim Form" and feels it answers the many criticisms levelled at the initial effort.

Meanwhile, the MSMS committee has met with a regional member of the federal Bureau of Health Insurance regarding whether the Social Security Administration will allow reporting for the Medicare Section of Michigan BC/BS on the Uniform Claim Form. The committee is aware of the stringent limit on the proliferation of new forms by the Federal Office of Management and Budget. We then understand the reluctance of SSA to offer any new form for reporting Part B claims than its own unless more states than Michigan will adopt our form. We are convinced that the present "Michigan Medical Claim Form" is the best revision of the AMA Uniform Claim Form. We will attempt to "sell" our form to several large state medical societies, who, if they can achieve such for their states, may help convince SSA of the merits of accepting our form.

Doctor Bryan

Finally, the MSMS Committee on Uniform Claim Form and Coding Procedure has been advised that the Health Insurance Association of America favors the AMA form if any be substituted for their current Health Insurance Council approved form. They are not in need of a form adaptable to OCR since manual processing of essentially all claims to them will continue for some time. Therefore, since the Michigan claim form does include all necessary data elements required by commercial carriers, a physician's office can include these items on the claim form initially and send copies of the original if there is need for more than one report for patients having multiple coverage.

Thoughts of a team physician

By Andrew V. Bedo, MD
Mt. Pleasant

Doctor Bedo is staff physician, Central Michigan University Health Services, and assistant clinical professor of human development at Michigan State University College of Human Medicine. He also is chairman of the Sports Medicine Committee, MCAAP.

(The following is reprinted, with permission, from the Michigan Chapter Newsletter, American Academy of Pediatrics. The author's insights into human relations are interesting and entertaining.)

I would like to focus on a few areas that may be of special interest to the physician who finds himself/herself caught up in the maelstrom of the wonderful world of junior sports.

We must begin with the conviction that the human body, as the mind, must be developed to its maximum potential; it must be trained, tried, and tested. It would indeed be inconsistent to wish to develop musical and academic talent, but neglect the athletic. While giving all a chance to participate and develop good habits of fitness, special abilities should be looked for and developed. (If this be elitism, make the most of it.) It is indeed a privilege to be part of this process, and it is our job to see that it

(Continued on page 692)

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is conducted properly, safely, offering the greatest possible benefit to all the participants.

In order to be a sports physician it is not necessary to have been an athlete, but it helps to have experienced the exhilaration of victory, the frustration of defeat, the pain of injury and the self discipline of rehabilitation. It is good to have had one or more youngsters in the athletic program to have empathy with the parents and the participants.

One must not be an introvert in this business. We must have poise to be able to "perform" in a suddenly hushed stadium under the gaze of a torrent of eyes. A good working relationship with our colleagues in the surgical specialties with a hot-line to one who is available immediately and will not put you on "hold" is essential. So is the respect and cooperation of the local and state police. And of course the ambulance crew and the hospital emergency room personnel must be "in your pocket."

Doctor Bedo

Now that we are on the athletic field, let's discuss our relationship with the coaching staff. Our attitude should never be superior, supercilious, or patronizing. The majority of these people are intelligent, well educated, and dedicated to the youngsters under their supervision. We must remember, that under our present permissive system these are just about the only educators who still command a modicum of the respect of the students and still have a chance to instill a certain amount of self discipline. They constantly have to fight for their program with the administration (budget), alumni (to produce winning teams), parents (to make 100 lb. junior the starting fullback). *We* have our troubles, *they* have theirs. If we discuss our basic principles with the coaching staff before the season starts and spell out the details, we shall avoid misunderstandings when the battle starts.

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Mass physical examinations were always a problem, but they are even more vexing now since women's sports came into their own and we have to perform in addition to the boys several hundred girl's examinations. I am the first to admit that females are more polite, more patient, smell better, and the noise they make is more like a massed chirrup of many sparrows than a loud rambunctious roar of many bulls. Still mass physicals aren't very satisfactory. They are not "worthless" because one can pick up an aortic murmur, an obvious hernia, an old nephrectomy scar, but it makes me shudder to think what we may miss. Theoretically the good old family doctor should do this, but this rarely occurs for two major reasons: 1. The parents of the child feel that the charge is too high, and 2. "We can never get in to see him." Translation: "We can never get in to see him the day before the season starts without an appointment and for free." I would suggest a roster of "deputy" team physicians on a sports medicine committee who would establish a schedule to examine 3 to 4 athletes a day starting in the spring. Here we run into "rules" that state that these examinations cannot be performed earlier than a certain date. The rules must be changed. There are always physicians interested in sports, fitness in general, or have one or more kids in the program who are willing to share the load, and will also take turns in covering events.

Our relationship with the family physician must be ethical and correct. His decision is final, don't criticize him/her in front of the parents or the youngster. Inform him/her of your disagreement over a cup of coffee, a phone call, or by letter. The decision will have to be his/hers.

We can be very helpful to athletes (and their parents) in making intelligent assessments of their potential. These kids come in amazingly assorted sizes and shapes. We can be very helpful to the 13-year-old Latin lad, perfectly developed, now starting linebacker of the junior varsity, if we point out to him that he best switch to wrestling next year, because his growth process is now pretty much over, and come next fall he may have difficulty in looking over his teammates' shoulders standing on the sidelines. Young, roly poly Ole Swenson, (not a feather on him, however) can be reassured that in a rather short while he probably will be one of the largest. The 13-year-old lass Lolita must be warned that she better continue her exercise program and eat carefully, lest she'll have a weight problem soon, whereas little beanpole 22-22-22, can be comforted that she'll be just as pretty as her mommy and will probably be a very creditable member of the women's basketball team. These things can be discussed with worried parents, and certainly with the coaching staff to make the right kind of plans for the future of the youngsters and the team. Of course, rarely these kids can fool you, but not very often, especially if you know their parents and know something of their genetic background.

Doctor Smith

'Cuckoo's Nest' good movie, but gives wrong picture

By Donald C. Smith, MD
Lansing

(The following is reprinted with permission from the July 22 issue of Link, *the official newsletter of the Michigan Department of Mental Health.)*

Who's crazy? Are we or are they? That's the provocative question Director Milos Forman asks in the Academy Award winning film, "One Flew Over the Cuckoo's Nest."

The setting is state hospital, U.S.A., circa 1962. McMurphy, the charming delinquent enters the world of the mentally ill in the opening scene — not because he is mentally ill but because he's a discipline problem in the local reformatory.

As the reels turn, it becomes increasingly clear that McMurphy's love of life and gusto, his charm and street know-how, his instinctive survival skills will be no match for the cold, polished efficiency of Nurse Rachet and her citadel.

Doctor Smith is director of the Michigan Department of Mental Health.

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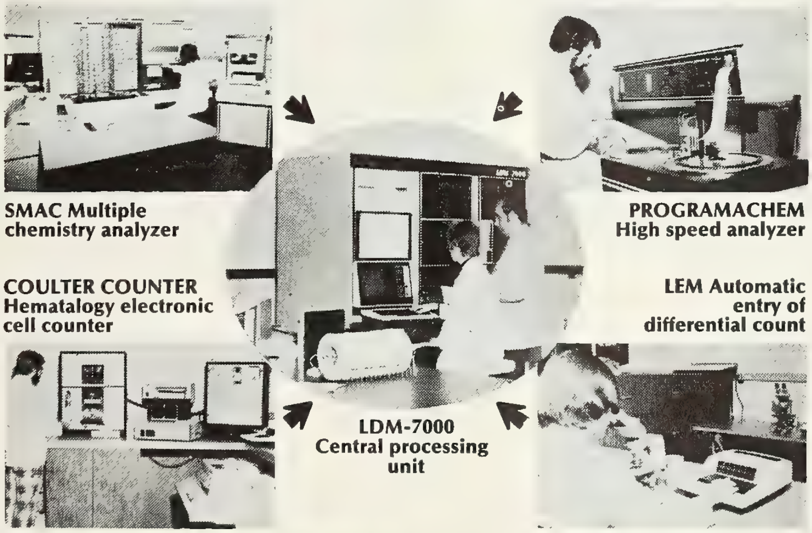
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COMMENTARY/*Continued*

As we leave the theatre, the answer is clear. It is us — society in general and the mental health establishment in particular that's crazy. Not the patient.

It's a great plot, albeit an old one. In this era, of disenchantment with big government and big business, Author Kesey's plot has mass appeal.

No film in the last four decades has earned as many Academy Awards. I'm no film critic, but I'm not surprised at the judgments of the experts. The acting is superb and the photography excellent. Director Forman builds his tale slowly, carefully, skillfully from the opening scene through the dramatic finale.

From my perspective it's an interesting piece of film art. If you haven't seen it, it's worth your time.

However, in view of its popularity, I am concerned about what it does to increase public understanding of mental illness and its treatment. Not much is my conclusion. In fact, it perpetuates (directly or through implication) a score or more of myths that we have been fighting for a long time.

Myth one: Once mentally ill, always mentally ill. The time sequence in "Cuckoo's Nest" spans a year or more. The seasons change but the characters do not. They will live out their lives, it is implied, on that ward. In Michigan mental hospitals today, half the persons admitted will be released in less than 30 days.

Myth two: Electroshock is used indiscriminately, and may be dispensed as punishment for patients who violate the rules. In Michigan, written authorization from patient or guardian must be obtained and entered in the medical record. If convulsive therapy is deemed advisable and consent cannot be obtained, the hospital must petition the probate court to hold a hearing and consent to the procedure.

The Clinical Center of Michigan State University, MSU's first building designed for providing health care to the public, was opened formally Oct. 22. A full range of outpatient health services will be offered on a phased-in basis by faculty in MSU's College of Human Medicine, College of Osteopathic Medicine and the School of Nursing through the University's Office of Health Services. Along with patient care, there will be emphasis on teaching of nearly 1,000 medical and nursing students.

Myth three: Public psychiatric hospitals are used as lock-ups for persons who are disruptive in the community. In the last fiscal year (1974-75) 58 percent of the people admitted to Michigan's state hospitals came voluntarily, because they recognized they needed help. Those persons committed come to us only after their day in court where they may be represented, if they wish, by legal counsel.

Myth four: "State hospital" is really a euphemism for "state prison." Locked doors, barred windows and barbed-wire fences are the order of the day. It simply isn't true. Although we do have locked doors and protective screening on certain units, many patients live on open units. None of our regional psychiatric hospitals are surrounded by fence.

Myth five: Patients have no rights; the staff is all powerful and its decisions are not subject to challenge. In Michigan, under our new Mental Health Code, there is an elaborate system designed solely to protect the human dignity and rights of those we serve.

Myth six: Psychosurgery may be the final answer for a disruptive patient. No psychosurgery has been performed on a patient in a Department of Mental Health agency during the last two years, and none is anticipated. In the seven years preceding my tenure, 13 operations were performed. During this nine-year period, nearly 100,000 persons entered state hospitals for the mentally ill.

If space permitted, the myth list could be expanded.

"Cuckoo's Nest" is an interesting piece of film art. It may even serve to remind those of us in mental health that we have a deep personal responsibility to each of the patients who comes to us for help.

Based on a novel written fifteen years ago, it does not, however, shed any light on the role of public psychiatric hospitals in the seventies or on the problems of mental illness which we are committed to alleviate. But, "That's Entertainment."

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doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

- **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, abyrinthitis, and vestibular neuronitis.
- **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*
- **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 s one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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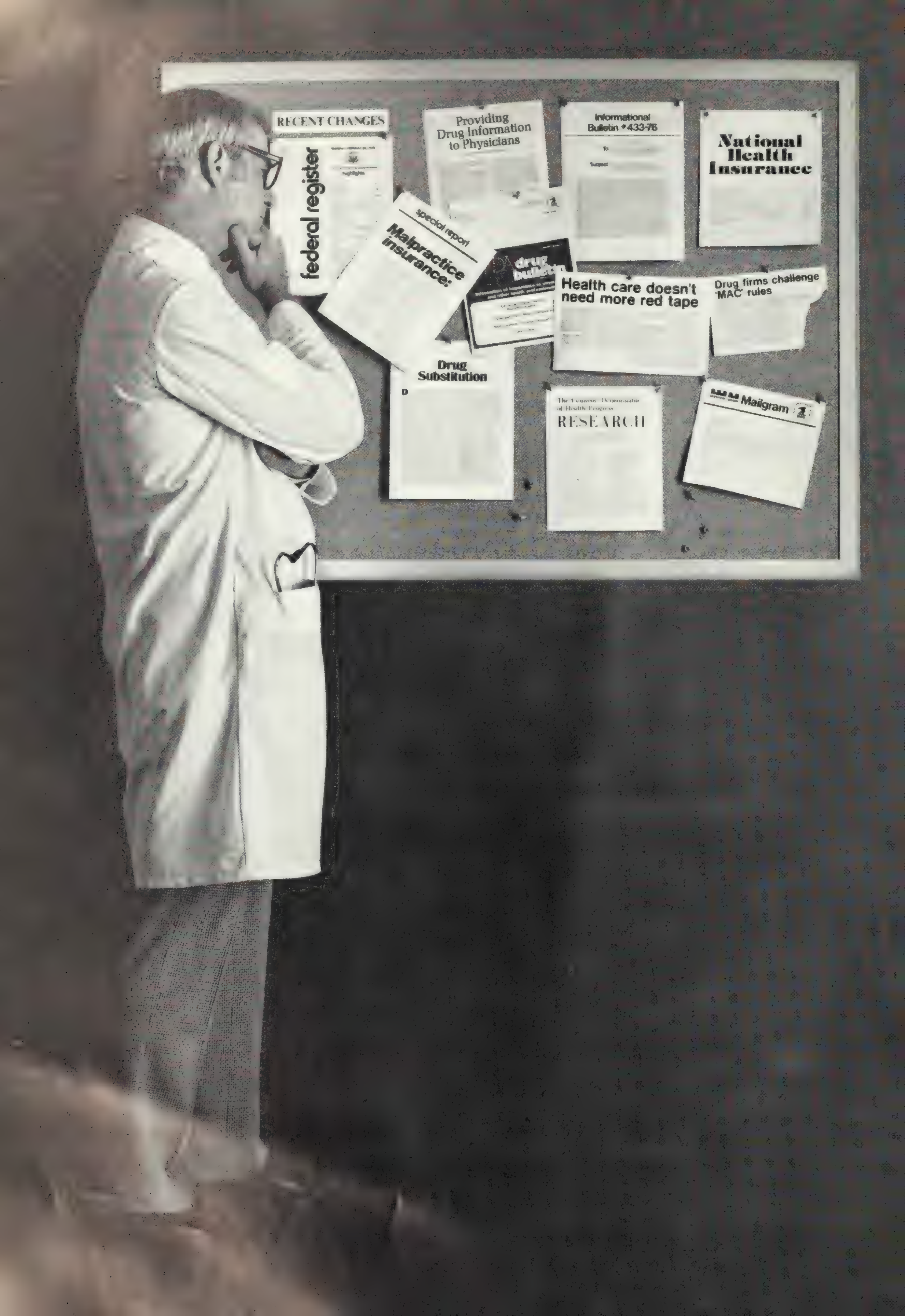
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

category 1 programs

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

DATE: Dec. 15, Lecture Series in Ophthalmology, "Intraocular Lens"
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Ophthalmologists
COST: No charge
CONTACT: Department of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Categeory I Credit

* * *

DATE: Jan. 4-Mar. 22, Radiologic Physics II
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
SPONSOR: WSU Department of Radiology
FOR: All interested physicians
COST: $66
CONTACT: WSU Division of CME**
APPROVED FOR: 2 hours per session, 20 course hours of Category I Credit

* * *

DATE: Jan. 5-March 23, Clinical Nuclear Medicine I
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
SPONSOR: WSU Department of Radiology
FOR: All interested physicians
COST: $66
CONTACT: WSU Division of CME**
APPROVED FOR: 2 hours per session, 20 course hours of Category I Credit

* * *

DATE: January 10 - March 26, Pathophysiology of Hemostasis
LOCATION: Scott Hall, WSU School of Medicine
SPONSOR: WSU-Department of Pathology
FOR: All interested physicians
COST: $100
CONTACT: WSU Division of CME**, Room 1209 Scott Hall, 540 East Canfield, Detroit, 48201
APPROVED FOR: 20 hours of Category I Credit, 2 hours per session

* * *

DATE: January 12-March 16, Medical Therapy — An Update
LOCATION: Saint John Hospital, Detroit
SPONSOR: Saint John Hospital
FOR: All interested physicians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road, Detroit, 48236
APPROVED FOR: 20 hours of Category I Credit

* * *

DATE: Jan. 13, Newer Concepts of Coronary Heart Disease: with Henry D. McIntosh, MD, of Baylor Medical College
LOCATION: St. Joseph Mercy Hospital, Pontiac
SPONSOR: Oakland Medical Center, St. Joseph Mercy Hospital
FOR: Cardiologists
COST: None
CONTACT: Jerome Rosenthal, PhD, Coordinator of Medical Education, St. Joseph Mercy Hospital, Pontiac, or Donald Dawson, MD, Medical Director, Oakland Medical Center, Pontiac
APPROVED FOR: 2 hours of Category I Credit

* * *

DATE: Jan. 17-21, Topics in Emergency Medicine
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
SPONSOR: WSU Department of Surgery
FOR: All interested physicians
COST: $150
CONTACT: WSU Division of CME**
APPROVED FOR: 30 hours of Category I Credit

* * *

DATE: Jan. 18, Detroit Cancer Club Seminar, Carcinoma of the Lung
LOCATION: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207
SPONSOR: WSU School of Medicine, Department of Oncology
FOR: All interested physicians
COST: $20
CONTACT: WSU Division of CME** or Melvin L. Reed, MD, 4160 John R., Detroit, 48201
APPROVED FOR: 2½ hours of Category I Credit

* * *

DATE: Jan 19, Lecture Series in Ophthalmology, "Indications for and Complications of Keratoplasty"
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Ophthalmologists
COST: No charge
CONTACT: Department of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Category I Credit

* * *

DATE: Jan. 24-28, Family Practice Review
LOCATION: Towsley Center, Ann Arbor
SPONSOR: U of M Office of Intramural Education
CO-SPONSOR: Michigan Association of Family Physicians
FOR: Family physicians
COST: $250

(Continued on page 700)

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CATEGORY I/*Continued*

CONTACT: U of M office of Intramural Education*
APPROVED FOR: 37½ hours of Category I Credit

* * *

DATE: Jan. 26, What's new in Obstetrics?
LOCATION: Saint John Hospital, Detroit
SPONSOR: Saint John Hospital
FOR: Obstetrics
COST: $50
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road, Detroit, 48236
APPROVED FOR: 7 hours of Category I Credit

* * *

DATE: Feb. 16, Lecture Series in Ophthalmology, "The CO_2 Laser in Ocular Surgery"
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Ophthalmologists
COST: No charge
CONTACT: Department of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Category I Credit

* * *

DATE: Feb. 21-25, Emergency Medicine
LOCATION: Towsley Center, Ann Arbor
SPONSOR: U of M Office of Intramural Education*
CO-SPONSOR: American College of Emergency Physicians, Michigan Chapter
FOR: Emergency physicians
COST: Approx. $250
CONTACT: U of M Office of Intramural Education*
APPROVED FOR: Approx. 36 hours of Category I Credit

* * *

DATE: February 21 - April 25, Pediatric Seminars - II
LOCATION: Saint John Hospital, Detroit
SPONSOR: Saint John Hospital
FOR: Pediatricians
COST: $200
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road, Detroit, 48236
APPROVED FOR: 20 hours of Category I Credit

* * *

DATE: March 1, Pathology Conference
LOCATION: Towsley Center, U of M Medical Center
SPONSOR: U of M Medical Office of Intramural Education
FOR: Pathologists
COST: $60
CONTACT: U of M Office of Intramural Education*
APPROVED FOR: Approximately 6 to 7 hours of Category I Credit

* * *

DATE: March 2-3, Advances in Pediatrics
LOCATION: Towsley Center, U of M Medical Center
SPONSOR: U of M Office of Intramural Education
CO-SPONSOR: Mich Chapter, American Academy of Pediatrics
FOR: Pediatricians
COST: $120
CONTACT: U of M Office of Intramural Education*
APPROVED FOR: 13¾ hours of Category I Credit

* * *

DATE: March 14-15, Difficult Problems Encountered in the Practice of General Surgery
LOCATION: Towsley Center, U-M Medical Center
SPONSOR: U of M Office of Intramural Education
FOR: Surgeons
COST: Approximately $120
CONTACT: U of M Office of Intramural Education*
APPROVED FOR: Approximately 13 to 14 hours of Category I Credit

* * *

DATE: March 15, Cancer of the Colon and Rectum
LOCATION: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207
SPONSOR: WSU Department of Oncology
FOR: All interested physicians
COST: $20
CONTACT: WSU Division of CME**
APPROVED FOR: 2½ hours of Category I Credit

* * *

DATE: March 16, Lecture Series in Ophthalmology, "The Treatment of Lid Elevation"
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Ophthalmologists
COST: No charge
CONTACT: Department of CME, Sinai Hospital of Detroit ****
APPROVED FOR: 2 hours of Category I Credit

* * *

DATE: March 23, Infant Nutrition: A Foundation for Lasting Health
LOCATION: Veteran's Memorial Building, 151 West Jefferson Avenue, Detroit
SPONSOR: The University of Iowa College of Medicine, and the National Heart, Lung and Blood Institute
CO-SPONSOR: The National Kidney Foundation, The Committee on Atherosclerosis and Hypertension in Childhood, and the Council on Cardiovascular Disease in the Young of the American Heart Association
FOR: All interested physicians, via a closed circuit symposium
COST: None
CONTACT: Pat Coleine, Health Learning Systems Inc., c/o Health Projects International, Inc., 200 Madison Avenue, New York, 10016
APPROVED FOR: 34 hours of Category I Credit, (The TV symposium: 3 hours, Pre & Post Tests:

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902.

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000

14 hours, Supplementary study: 8 hours, Visiting Faculty: 9 hrs)

* * *

DATE: March 23, Heart Day
LOCATION: Saint John Hospital, Detroit
SPONSOR: Saint John Hospital
FOR: Cardiologists
COST: $50
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road
APPROVED FOR: 7 hours of Category I Credit

* * *

DATE: March 23 - June 7, Physics of Nuclear Medicine and Diagnostic Radiology
LOCATION: Scott Hall, Wayne State University
SPONSOR: WSU Department of Radiology
FOR: Radiologists
COST: $66
CONTACT: WSU Division of CME**
APPROVED FOR: 20 hours of Category I Credit, 2 hours per session.

* * *

DATE: March 20 - June 8, Clinical Nuclear Medicine II
LOCATION: Scott Hall, Wayne State University
SPONSOR: WSU Department of Radiology
FOR: Radiologists
COST: $66
CONTACT: WSU Division of CME**
APPROVED FOR: 20 hours of Category I Credit, 2 hours per session.

* * *

DATE: March 26-27, AMA Regional Program
LOCATION: Michigan Inn, Southfield
SPONSOR: AMA and MSMS
FOR: All interested physicians
COST: $10 per credit hour
CONTACT: AMA Council on Scientific Assembly, 535 N. Dearborn, Chicago 60610
APPROVED FOR: To be determined

DATE: March 30-31 — Annual Michigan Conference on Maternal and Perinatal Health
LOCATION: Kalamazoo Center Inn, Kalamazoo
SPONSOR: MSMS
FOR: All interested physicians
COST: None
CONTACT: Herbert Auer, MSMS headquarters
APPROVED FOR: Tentative 7 hours of Category I credit

* * *

Continuing Courses

DATE: Every Friday, through July, 1977, Neurology Conference
LOCATION: 4 Morse Auditorium, Harper Hospital

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Suite 350, 6785 Telegraph Road, Birmingham, 48010, Telephone: (313) 647-6640
GRAND RAPIDS OFFICE: G. J. Haworth, Representative
143 Cortland Avenue, Rockford, 49341, Telephone (616) 866-9395

CATEGORY I/*Continued*

SPONSOR: Wayne State University Department of Neurology
FOR: Internists, neurologists, neurosurgeons, pediatricians, family doctors
COST: None
CONTACT: Beverly Wolf, Department of Neurology, 3990 John R, Detroit, 48201
APPROVED FOR: 2 hours Category I Credit

* * *

DATE: Every Saturday, Weekly Conference
LOCATION: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey
SPONSOR: Burns Clinic/Little Traverse Hospital
FOR: All interested physicians
COST: None
CONTACT: Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770
APPROVED FOR: Hour-for-hour Category I Credit

* * *

DATE: Begins September, 1976, Continuing Training in Family Therapy
LOCATION: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield
SPONSOR: Family Institute of Southeastern Michigan
CO-SPONSOR: Ackerman Institute
FOR: Psychotherapists
COST: Varies according to time put in
CONTACT: Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan
APPROVED FOR: Hours vary with time spent

* * *

DATE: Saturdays, Morbidity and Mortality Conference
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital Department of Surgery
FOR: Surgeons
COST: None
CONTACT: Office of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Category I Credit per session

* * *

DATE: Monthly, Cleft Palate Clinic
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Oral Surgeons, plastic surgeons, pediatricians
COST: None
CONTACT: Office of CME, Sinai Hospital of Detroit****
APPROVED FOR: 3 hours of Category I Credit

* * *

DATE: Monthly, Tissue Audit (Cancer)
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Surgeons, ob-gyns, pathology, radiology
COST: No charge
CONTACT: Office of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours per session Category I Credit

The following have been accredited by MSMS Commission on Continuing Medical Education as of Sept. 1, 1976.

Organizations:

Ann Arbor Psychiatric Association
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
University of Michigan School of Public Health

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Southfield
Saginaw Cooperative Hospitals Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V. A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
Ypsilanti State Hospital, Ypsilanti

20/150 H

20/100 EAR

20/70 ING IS

20/50 AS PRECIOUS

20/40 AS SIGHT HAV

20/30 YOU HAD YOUR HE

20/20 TESTED LATELY A SI

20/15 COMFORTABLE HEARING

20/10 INVESTMENT OF A FEW MIN

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

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Beltone
WHEN A HEARING AID WILL HELP

PTA parenting project needs professionals' cooperation

By Chris Valmassei
Special to **Michigan Medicine**

There is a crisis in parenting in society today.

The statistics on birth defects, teen suicides, runaways, drug addiction and illegitimate births are just a few of the signs. And they don't show promise of improving in future generations.

But physicians can and do play a vital role in helping to educate people on the issue, according to a Michigan PTA leader.

Two organizations, the Michigan Parent Teacher Association (PTA) and the March of Dimes, have joined forces to make people aware of the crisis and help educate them to be better parents.

"We could all do a better job of being parents," said Mrs. Mildred Chadderdon, Parenting Project Director for the Michigan PTA. "But doctors are a very credible source in society today," she said. "They can be heard above us average parents."

One way she thinks doctors can help in the project is by making themselves available as resources for panel and other discussions on the topic of parenting. "They could provide input from the medical aspect," she said.

She called on physicians to acquaint the general public with the true picture of parenting. "They could point out the lack of sound health, both in young parents and their babies," she said. "Many birth defects are the result of poor nutrition on the part of the young mothers."

Statistics on the incidences of venereal disease and teen-age pregnancies should be brought to the attention of the public, she said. "Everyone always says 'that can't happen here,' " she said. "But the truth is they do happen here, in the smallest towns and to the best families."

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See You Again at the Next MSMS Convention

Teenage pregnancies dangerous

According to Joan Stryker, MD, chief of the outpatient clinic at Hutzel Hospital in Detroit, teenage pregnancies are serious to the mother and the baby.

"Pregnancy at this age is a disaster for everyone," she said. "Mothers under 20 have a 30 percent higher death rate from such complications as toxemia. The chances of the baby being born dead are 15 percent higher."

There are more cesarean births in this age group because the mother's body is not developed and labor is more prolonged; the chances of premature births are 36 percent higher; infant deaths under one year are 30 percent higher.

Mrs. Chadderdon also asked doctors to continue to make referrals to the various public health and social service agencies available to young pregnant girls in the communities throughout the state.

"Many counties have excellent services available for young girls for free or a nominal fee," she said. "But the girls are often not aware of them. If private physicians would refer these girls to these services, maybe it would help the parenting crisis."

An example of the magnitude of the problem is the incidence of child neglect and abuse in the country. Babies deliberately cut, burned, with broken limbs and blinded eyes are only a few of the products of the rampant crisis.

Statistics tell story

Some of the "harsh facts" are:

- In 1975, one out of every 14 babies was born damaged or defective — almost 250,000 per year. Most are born too soon or too small and account for 70 percent of all infant deaths.
- In the United States, the richest and most powerful country in the world, 40,000 infants die annually in the first four weeks of life; 19,000 more die before their first birthday.
- Adolescent pregnancies are soaring and account for most of the infant deaths and defects. Mothers under 20 are classified as "high risk." In 1975, there were 900,000 pregnancies in school girls under the age of 18 and one of every three suffered significant complications.

From 1960 to 1973, live births to mothers 16 and 17 rose by 25 percent. Births to girls under age 16 rose 80 percent. Births to 11, 12 and 13-year-olds are no longer uncommon.

It is estimated that between 1975 and 1980, there will be a minimum of one million live births to high-risk, adolescent mothers.

- Although our birthrate is down to population zero, two-thirds of the next generation will be disadvantaged from birth physically, economically and emotionally.

Mrs. Chadderdon envisions the PTA working through other organizations to involve the whole community. She said audio-visual materials on the subject are available for schools and other groups.

"What we need in society is an awareness of the need for improved parenting skills," she said. "We've got to impress on our young people the importance of these skills and this involves the home, schools, churches and the community.

"Being a parent is probably the most responsible job most of us will ever have, yet it is the one for which we are least prepared," she said.

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Robert J. Bahra, M.D.
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Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Robert L. Fransway, M.D.
Carlos M. Lauchu, M.D.
Alma MacLeod, M.D.
Hubert Miller, M.D.
Jacob J. Miller, M.D.
Satya Pasricha, M.D.
Richard Pfrender, M.D.
Arcadio V. Ramirez, M.D.
David L. Reive, M.D.
Gerald M. Schmit, M.D.
Joseph J. Tiziani, M.D.
Prehlad S. Vachher, M.D.
Richard D. Watkins, M.D.
Robert M. Zimmerman, M.D.

Medical Practice Board

October and November Summary of activities

By Sherry Wellman, Government Agency Liaison

The Michigan Medical Practice Board recently

(1) Noted with regret the resignation of John W. Moses, MD, who has moved to Ohio to accept a position as associate director for medical affairs with Akron City Hospitals and as associate dean of Northeastern Ohio Universities School of Medicine.

(2) Re-elected Frederick W. VanDuyne, MD, as president of the Board. John R. Wilson, MD, of Grand Rapids was elected vice-president and Donald H. Kuiper, MD, of Lansing was elected secretary.

(3) Received a ruling from Attorney General Frank Kelley that the Board not only has the authority to write rules controlling public access to its records, but also has a duty to develop those rules. He told Board President Doctor VanDuyne that the Board must set confidentiality standards, even though the Department of Licensing and Regulation actually handles the records and performs all administrative work.

(4) Adopted changes in the rules for the continuing medical education law which will be effective for meeting 1978 licensure requirements. If approved by the Joint Administrative Rules Committee of the Legislature, the rules will allow CME credit for specialty board re-certification and for tutorial experience and will delete the requirement that the reporting form be notarized.

(5) Adopted a resolution requesting the Attorney General to continue to bring injunctive actions against persons allegedly practicing medicine in violation of the Medical Practice Act. The Attorney General has brought several suits to enjoin chiropractors from continuing a public nuisance through the alleged practice of medicine. The Ingham County Circuit Court issued an opinion which noted that while the Attorney General has the authority to enjoin a public nuisance, suits brought in violation of the Medical Practice Act should properly be brought on relation (on request) of the Medical Practice Board. The resolution adopted by the Board clarifies the issue that the AG is acting on request of the Board.

Disciplinary Actions, July-October

(1) Recalled the annual license of Robert E. Pucelik, MD, and issued a limited license to complete residency requirements in psychiatry at Traverse City Hospital until the end of the residency, three years.

(2) Reinstated the license of Marshall L. Follo, MD, with certain limitations regarding type of practice, continued medical care and Board evaluation of progress at the end of one year.

(3) Entered into an agreement with Maurice J. Smith, MD, including voluntary surrender of his controlled substance registration for one year and demonstration of educational experience in therapeutics.

(4) Revoked the license of Preston W. Ports, MD, for failure to use reasonable care and discrimination in the prescribing and dispensing of drugs; failure to conform to minimal standards of acceptable and prevailing medical practice, in violation of Sec. 11 (2) and Sec. 11 (2) (i) of Medical Practice Act. Final decision is in the court.

(5) Amended the limited license restriction of James M. Cook, MD, to permit the practice of medicine one day per week.

(6) Suspended for 90 days the license of Wesley B. Mikesell, Jr., MD, and suspended his controlled substance registration for one year. Also issued an official letter of reprimand. Effective date of agreement, December 1, 1976 to March 1, 1977.

(7) Suspended for 90 days the license of Maurice J. Smith, MD, and suspended his controlled substance registration for one year. Effective date of agreement, December 31, 1976 to March 30, 1977.

Medico-Legal

"Surgeon May Not Testify to Standard of Care For Reading X-Rays"
Michigan Court of Appeals, Feb. 10, 1976
from *The Citation*, Vol. 33, No. 10

"Blood Transfusion Suit Dismissed"
Michigan Court of Appeals, Feb. 19, 1976
from *The Citation*, Vol. 33, No. 11

welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Inderjit Aggarwal, MD
3737 Beaubien, #606
Detroit 48201

Kyung Sik Ahn, MD
3079 Shattuck Arms, #3
Saginaw 48603

Harold M. Arrington, MD
3800 Woodward Ave., #502
Detroit 48201

Seyed A. Bakhshandeh, MD
19930 Farmington
Livonia 48152

Wayne A. Bare, MD
517 Wildwood
Jackson 49201

David Blum, MD
46040 Lake Villa, #306
Belleville 48111

Cecilia A. Buot, MD
8844 Joy Rd.
Detroit 48204

Carlo Corsetti, MD
17141 Hayes
Detroit 48205

Sham Lal Dahiya, MD
14800 W. McNichols
Detroit 48235

Ashokkumar J. Desai, MD
1065 Willa Park Dr.
Troy 48098

Leopoldo W. Eisenberg, MD
22341 W. Eight Mile Rd.
Detroit 48219

Walter O. Evans, MD
20925 Lahser Rd., #511
Southfield 48075

Behrooz Faiz-Mahdavi, MD
5200 Anthony Wayne Dr.
Detroit 48202

Robert E. Gardner, MD
P.O. Box 130
Ironwood 49938

Gary R. Gazella, MD
23100 Cherry Hill
Dearborn 48124

Ramiro Hernandez, MD
9572 Pickwick Circle
Taylor 48180

Martin L. Jackier, MD
8413 Hendrie
Huntington Woods 48070

Olan Jareunpoon, MD
26451 Ryan Rd.
Warren 48091

James K. Johnson, MD
3800 Woodward Ave.
Detrot 48201

Steven Korpi, MD
1101 S. Mission
Mt. Pleasant 48858

Chitranjan Lall, MD
19451 Argyle Crescent
Detroit 48203

Edward S. Lerchin, MD
11885 E. 12 Mile Rd.
Warren 48093

James B. Lesser, MD
4580 Rolling Ridge
West Bloomfield 48033

Frankie E. Mac, MD
P.O. Box 657
Troy 48099

Melvin A. Magidson, MD
Sinai Hospital
Detroit 48235

Vasudeva Rao Mandava, MD
3305 Coolidge Hwy.
Royal Oak 48072

Edward Manring, MD
P.O. Box 559
DeWitt 48820

Appa Rao Mukkamala, MD
Hurley Medical Center
Flint 48502

Hasmukh I. Patel, MD
2432 Crooks Rd.
Troy 48084

Dorothy A. Porter, MD
1834 Wickham
Royal Oak 48073

Tallam Janardan Rao, MD
P.O. Box 494
Grant 49327

Chandra S. Reddy, MD
39880 Van Dyke
Sterling Heights 48078

Angelo V. Rivera, MD
P.O. Box 318
Hillsdale 49242

Juan Carlos Rojas, MD
27387 Parkview Blvd.
Warren 48092

James M. Ryan, MD
P.O. Box 130
Ironwood 49938

Andres G. Santiviago, MD
14 Belleview
Mt. Clemens 48043

Leonard B. Savoy, MD
VA Hospital
Allen Park 48101

Deeb Shalhoub, MD
1861 Trenton
Trenton 48183

Everett B. Simmons, Jr., MD
18510 Meyers
Detroit 48235

Philip T. White, MD
28 W. Adams
Detroit 48226

Ador B. Yan, MD
3105 Carpenter
Detroit 48212

In Taik Yoon, MD
319 W. Delaware
Decatur 49049

MONTHLY SURVEILLANCE REPORT

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the four-week period ending Oct. 29, 1976

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

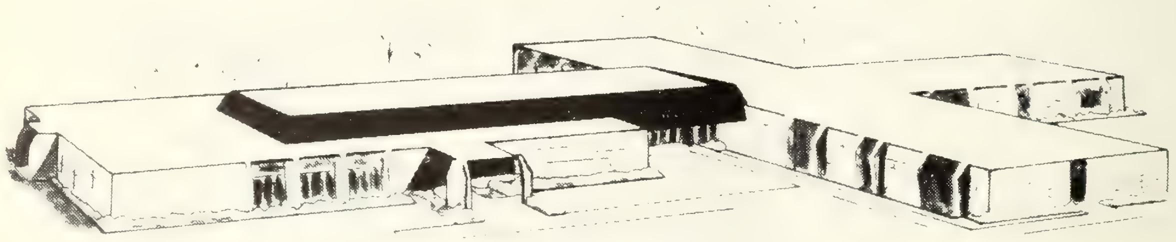
	1976 This 4-Week Period	1975 Same 4-Week Period	1976 Total To Above Date	1975 Total Same Date	Total Cases for 1975
Rubella	28	78	1,405	1,497	1,975
Cong. Rubella Syndrome	0	0	0	1	1
Measles	29	46	5,877	3,062	3,253
Whooping Cough	3	8	61	73	98
Diphtheria	0	0	0	1	1
Mumps	98	219	4,943	8,305	9,979
Scarlet Fever & Strep Sore Throat	1,786	1,626	19,675	18,738	23,777
Tetanus	1	0	2	0	0
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	243	186	2,192	2,343	2,877
Salmonellosis (other than S. typhil)	60	65	732	692	864
Typhoid Fever (S. typhil)	1	2	9	7	10
Shigellosis	31	58	459	630	745
Aseptic Meningitis	31	49	137	226	280
Encephalitis	7	39	70	119	168
Meningococcic Meningitis	6	4	57	68	76
H. Influenza Meningitis	9	5	105	104	142
Tuberculosis	97	96	1,139	974	1,220
Syphilis	88	130	873*	1,365	1,614
Gonorrhea	2,967	2,902	28,621	26,450	32,472

Information can be supplied by the local health department on local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

*Correction

FOREST VIEW PSYCHIATRIC HOSPITAL



Jack N. Carr, MD, Medical Director

Located on six beautifully wooded acres, *FOREST VIEW HOSPITAL* is Michigan's newest private psychiatric facility, specializing in short term intensive treatment. Comprehensive adjunctive therapy, including occupational and recreational therapy is emphasized. The prime goal of the hospital personnel is to aid the patient in coping with his illness and return him to community life as soon as possible. Licensed by the State of Michigan, Department of Mental Health, Accredited by the Joint Commission of Accreditation of Hospitals, Participant in Medicare and Medicaid.

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Michael H. Payne, Administrator

Grand Rapids, Michigan 49506
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In Memoriam

Clarence L. Candler, MD
Grosse Pointe Woods

Long-time Detroit physician Clarence L. Candler, MD, died Oct. 15 at the age of 86. Doctor Candler was a past president of the Wayne County Medical Society and the Detroit Board of Health, and served 10 years as a delegate to the MSMS House of Delegates. Doctor Candler was the first chief of staff at St. John Hospital and was voted hospital "man of the year" in 1965. Doctor Candler retired in 1951, but continued to treat many area accident victims in his home. He was a graduate of Wayne State University School of Medicine.

Keith D. Coulter, MD
Venice, Fla.

Longtime Gladwin family physician Keith D. Coulter, MD, died Oct. 24 at the age of 75. He had resided in Florida following his retirement in 1958. Doctor Coulter was a graduate of Northwestern University medical school and was affiliated with the Gladwin Hospital. He was past president of the North Central Counties Medical Society, and had served as Gladwin County medical examiner.

Frank Diskin, MD
Muskegon

Frank Diskin, MD, Muskegon family physician, died Oct 11 at the age of 71. Doctor Diskin was affiliated with Hackley and Mercy hospitals of Muskegon, as well as the American Academy of Family Physicians, the American Geriatrics society and the American Heart Association. He was a graduate of Wayne State University School of Medicine.

Robert Horn, Jr., MD
Grosse Pointe Shores

The chairman of the Henry Ford Hospital Department of Pathology since 1955, Robert C. Horn, Jr., MD, died Oct. 4 at the age of 63. Doctor Horn was named 1976 pathologist of the year by the American College of Pathologists and the American Society of Clinical Pathologists. He had served as president of the college. He also was past president of the Michigan Society of Pathologists and the Arthur Purdy Stout Society, was a member of the International Academy of Pathology and was author of more than 100 medical articles and books. He was a graduate of Yale Medical School and had been active on Wayne County Medical Society committees.

L. A. Poznak, MD
Midland

The former head of the radiology department of Midland Hospital, Leonard A. Poznak, MD, died Sept. 24 at the age of 64. Doctor Poznak had served on the University of Michigan Medical School faculty and founded the radiology department at Midland Hospital. He was past president of the Midland County Medical Society and was a member of the American College of Radiology and the Eastern Radiological Society.

Aaron D. Riker, MD
Pontiac

Aaron Dudley Riker, MD, Pontiac otolaryngologist for over 50 years, died Oct. 18 at the age of 81. Doctor Riker retired in 1973 as chief of staff at Pontiac St. Joseph Mercy Hospital. He was a graduate of the University of Michigan Medical School and was affiliated with St. Joseph Mercy, Pontiac General, and William Beaumont hospitals. He was past president of the Oakland County Medical Society, and a fellow of the American College of Surgeons, the International College of Surgeons, as well as a member of several other professional organizations.

Doctor Taylor

Ross V. Taylor, MD
Traverse City

The former chairman of the MSMS Council for four years, Ross V. Taylor, MD, died Oct. 26 at the age of 62. Doctor Taylor served as Council chairman from 1968 to 1971, as a councilor for six years and as a member of the MSMS House of Delegates for over 10 years. He was past president of the American Society of Internal Medicine and the American Therapeutic Society and former Michigan Governor of the American College of Cardiology. Doctor Taylor also was past president of the ASIM Foundation for Socio-Economic Research.

Doctor Taylor was chairman of the Research Protocol Review Committee for the Michigan Department of Corrections for several years. He had served as president of the Michigan Society of Internal Medicine and the Michigan Heart Association, and was a fellow of the American College of Physicians and the American College of Cardiology. He had been active in civic affairs, was former chief of staff of Jackson Mercy Hospital and chairman of the board of Jackson's Foote Hospital. He practiced in Jackson until his recent move to Traverse City. Doctor Taylor was a graduate of the University of Nebraska medical school. His three sons also are physicians.

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Attractive office space now available for rent in the Muskegon Mall area. Located in the Medical Arts Plaza, 315 West Clay Avenue, Muskegon, Michigan. Reasonable rates with many modern conveniences. For further information please contact Mrs. Westerman, (616) 726-3461 or after 5:00 p.m. (616) 725-7120.

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INGHAM COUNTY HEALTH DEPARTMENT — MEDICAL DIRECTOR: This is a professional position, either an M.D. or D.O., who provides medical consultation to the Health Administrator, provides direction to the medical components of health programs within the department, and provides specific physician services of acceptable medical practice and works under policies and administrative guidelines established by the Board of Health through its administrator.

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QUALIFICATION REQUIREMENTS:

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Please send resume to: Mr. Young, Personnel Director, Ingham County Personnel Department, 121 E. Maple, Mason, Michigan 48854.

Family Physician, Board Certified or qualified. Could be residency trained or qualified by active practice. Wanted for position as third full time faculty in accredited established community based Family Practice Residency Program in Michigan. Should be interested in curriculum expansion and teaching Family Practice residents and medical students. Faculty position on Michigan State University College of Human Medicine. Salary commensurate with training and experience. Good Fringe package. Send Curriculum vitae to: Robert J. Toteff, M.D., Director, Family Practice Center, 705 Cooper, Saginaw, Michigan 48602.

OBSTETRICIAN to associate with Ob-Gyn Department of established multispecialty group in St. Paul-Minneapolis and suburban areas. Excellent salary, generous fringe benefits. Tremendous growth potential in one of America's leading metropolitan areas. Curriculum vitae and references invited. Box 80100, St. Paul, Minnesota 55108.

Port Huron, Michigan: Board eligible or certified pediatrician to join a well established growing 2 man practice. Modern office facility. Active pediatric service including special care and newborn nurseries in a 280 bed general hospital serving the surrounding area of Eastern Michigan. Located on Lake Huron, 60 miles from University related Children's Hospital. Opportunity for participation in ownership within a year. Outstanding, progressive family community with excellent water and land recreation. Good public schools, Kindergarten-12th grade. Also, a 2 year community college. Contact: William D. Cleland, M.D., or Anthony C. Gholz, M.D., 1209 Tenth Street, Port Huron, Michigan 48060 (313) 985-7146.

NEEDED: Internists for the Traverse City, Oak Park, and Lansing offices of the Disability Determination Program under Social Security. Salary currently in high $30,000's plus 22% fringe benefits, including life, accident, longterm disability, and hospital insurance. Deferred compensation. Pension benefit after 10 years. No malpractice insurance required. 40 hour work week. No weekends or nights. 50 hours continuing medical education benefit. Job involves review of medical records, training and teaching, as well as some public relations. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Program, Box 30011, Lansing, Michigan 48909, OR call collect: David P. Gage, M.D., Chief Medical Consultant, (517) 373-7789.

PHYSICIAN WANTED: Vacancy for physician interested in mental retardation. This is a state institution caring for 1500 mentally retarded. Includes general hospital with ancillary services. Fringe benefits include medical and life insurance, sick leave, paid vacations, retirement, long term disability, etc. Michigan medical license required. Annual salary from $24,534 to $34,076 based on qualifications. Equal opportunity employer. Contact: Isak O. Berker, M.D., Medical Director, Oakdale Center for Developmental Disabilities, Lapeer, Michigan 48446.

PHYSICIANS WANTED: LaFollette Community Hospital, LaFollette, Tennessee is seeking an emergency room physician for immediate placement. Also, in need of family practice physicians, OB/Gyn and pediatricians. Guaranteed minimum $30,000 per year. Complete furnished office building adjacent to hospital. Located in East Tennessee, 45 miles north of Knoxville. Contact: J. B. Wright, Administrator, LaFollette, Tennessee 37766. Phone (615) 562-2211.

DOCTORS OFFICE — Waiting Room, Reception office, 4 examining rooms, Lab, Dark Room, and Consultation office (1200 sq. ft.) Available Jan. 1, 1977. New growing area at US 23 and M-59, Hartland, Mich. Call Tom Adler Realty Company — (313) 632-6222.

METAL PLAQUE — Honorary certificates, diplomas, photos, etc. perfectly reproduced in bright silver toned metal with black lettering, all the clarity of the original yet immune to deterioration. Mounted on richly finished walnut base 10 × 12 for only $34.95. Allow three weeks. Perma-Plaque, 778 Rivard, Grosse Pointe, Michigan 48230 (313) 884-9399.

PSYCHIATRIST: STARTING SALARY $35,-$45,000. Prefer two years experience in Community Psychiatry. To carry treatment and supervisory responsibilities in a progressive and growing community mental health center. Medical staff includes two full-time psychiatrists and a complement of psychiatric consultants. A reasonable work pace and pleasant facilities. Enjoy with us the benefits of living and working in a scenic, rural community on the Ohio River, with the added advantage of being only 30 minutes from downtown Cincinnati, Ohio. Contact James F. Jones, Executive Director, Community Mental Health-Mental Retardation Center, Inc., 285 Bielby Road, Lawrenceburg, Indiana 47025. Equal Opportunity Employer.

UROLOGIST, Age 31, married, trained at major New York City Medical Center, FMG, Available July 1977, Board eligible, seeks solo, group or partnership. Will consider all locations. Muhammad Javaid, M.D., (212) 823-8773.

TAX DEDUCTIBLE VACATIONS FOR MEDICAL PROFESSIONALS. Over 500 listings of national/international meetings in the medical sciences for 1977. Send a $10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

STATEMENT OF OWNERSHIP

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management and Circulation of Michigan Medicine, published four times in January and three times in all other months, 37 issues, mailed at East Lansing, Michigan, and additional post offices in Ingham County for December 1, 1974.

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I certify that the statements made by me above are correct and complete.

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potpourri

MSMS Council Chairman Ernest P. Griffin, Jr., MD, observes that one of the inconsistencies he sees occurs when Michigan physicians give scientific addresses and utilize many slides quoting *JAMA*. *JAMA* provides the scientific support for many of their observations. But . . . more than once these same doctors are not members of the AMA, MSMS or their component medical society. "These doctors take some of the advantages of AMA membership but they are not willing to pay the AMA dues that help to make *JAMA* and other services available to the doctors of the USA," declares Doctor Griffin.

* * *

"The expedient thing and the right thing are seldom the same thing," wrote Charles Brower, former chairman of Batten, Barton, Durstin and Osborn.

* * *

The "chicken pox" problems of handling mail spotted by Barbara Stahl, of the U-M Management Education Division, should interest doctors. She advocates that you should put a mark on every letter every time you shift it from one stack to another as you fail to deal with it. "Take action on every letter quickly or toss it," she advises. "Don't let letters get the chicken pox."

* * *

"The AMA is working hard to influence the media to follow a policy of greater fairness and objectivity in its reporting," so declares the AMA in ads that are running in national specialty journals and other publications. John J. Coury, MD, Port Huron, now an AMA Board member reports that the AMA is "devoting more money and manpower to overcome reporters' basic assumptions," and "that's a long-term educational job."

* * *

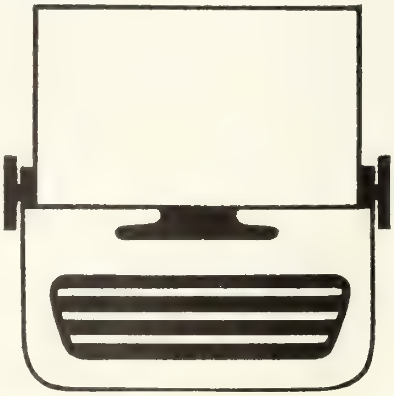
Consider the poor Swedes . . .

A businessman in Sweden who earns $36,000 a year pays $21,760 in taxes and retains only $13,240. A factory worker who earns $10,000 pays taxes of $3,800 and keeps only $6,200.

In return, the Swedish government provides many services. The welfare state provides a medical program under which the maximum price for a visit to a clinic is $3.40 — the government pays the rest.

* * *

Have you seen the book, "Rant and Rave," published by MSMS Past President James J. Lightbody, MD, of Detroit? It's light and fun. Doctor Lightbody's dislike for forms and paperwork pops up throughout the pages. Once, he pleaded "Oh, Aesculapius! Oh, Apollo! Grant us relief from this deluge of forms, blanks and questionnaires."



* * *

Business often gets angry — or outraged — at the press, just as some physicians do. James L. Ferguson, president of General Foods, recently wrote in Editor and Publisher magazine, that he objects to reporters who do not have the necessary background to handle business stories. Mr. Ferguson observes, "a slanted story can be the reporter's easy way out." He further objects to the appearance that reporters "presume the businessman is guilty" and that he has no public interest in any matters.

* * *

Certain wise sayings have been put together many ways. Philosopher Thomas Fuller in 1650 wrote, "It is always darkest just before the day of dawn." Sir Walter Scott in 1829 said, "We must not reckon our chickens before they are hatched, though they are chipping the shell now." Benjamin Disraeli in 1880 said it this way: "The darkest hour precedes the dawn."

* * *

Are boys and girls taller today than 20 years ago?

Is your answer, "yes"?

Well, the National Center for Health Statistics reports that the 100-year trend of youths outstripping their elders in size has ended. Boys and girls today are no taller than 20 years ago. The average 18-year old American boy today is 5-ft., 9.2-inches tall — much taller than the American Revolution soldiers who averaged five-foot-five.

* * *

In looking at WSU School of Medicine enrollment figures, there are 186 women students now among the 1,022 enrolled, contrasting with 47 women in 1966-67 out of a total of 516. The 186 women is the largest female enrollment ever. Of the 1,022 students attending WSU School of Medicine now, 964 are from Michigan. Figures provided by Marilyn Heins, MD, associate dean for student affairs, also show that there are 75 black medical students enrolled now, the largest black enrollment ever. The 28 black first-year students, largest number ever, include 19 males and nine females.

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